If delay suspected, specify below

DEVELOPMENTAL (age 0-6 yrs)

--- Head Start Only ---

Health Care Provider Signature

Other

Dietary Restrictions

--- Full diet ---

IMMUNIZATIONS – DATES

--- Full physical activity ---

IMMUNIZATIONS – DATES

--- Follow-up Needed ---

CIR Number of Child

--- Referral(s) ---

--- Recommendations(s) ---

--- Other ---

DOB: _/__/____

Provider License No. and State

Type of Exam:

Date: _/__/____

I.D. Number

Date: _/__/____

I.D. Number

Provider I.D.

DOB: _/__/____

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