

DEVELOPMENTAL TASKS											
NORMAL	ABNORMAL		NORMAL	ABNORMAL							
<input type="checkbox"/>	<input type="checkbox"/>	Kicks ball	<input type="checkbox"/>	<input type="checkbox"/>	Counts to three						
<input type="checkbox"/>	<input type="checkbox"/>	Opens door	<input type="checkbox"/>	<input type="checkbox"/>	Names one color						
<input type="checkbox"/>	<input type="checkbox"/>	9 cubes tower	<input type="checkbox"/>	<input type="checkbox"/>	Understands tired, cool and hungry						
<input type="checkbox"/>	<input type="checkbox"/>	Copies circles	<input type="checkbox"/>	<input type="checkbox"/>	Names at least one picture in animal book						
<input type="checkbox"/>	<input type="checkbox"/>	Does undressing	<input type="checkbox"/>	<input type="checkbox"/>	Speaks in short sentences						
<input type="checkbox"/>	<input type="checkbox"/>	Feeds self	<input type="checkbox"/>	<input type="checkbox"/>	Speaks intelligibly						
<input type="checkbox"/>	<input type="checkbox"/>	Knows full name, age and sex	<input type="checkbox"/>	<input type="checkbox"/>	Group play						
Describe abnormal findings:											
DIET/ NUTRITION			IMMUNIZATIONS				LABORATORIES				
Diet: _____			DTaP	<input type="checkbox"/>	#1	<input type="checkbox"/>	#2	<input type="checkbox"/>	#3	<input type="checkbox"/>	#4
Fluoride: <input type="checkbox"/>			IPV	<input type="checkbox"/>	#1	<input type="checkbox"/>	#2	<input type="checkbox"/>	#3	<input type="checkbox"/>	#4
Vitamins: <input type="checkbox"/>			Hib	<input type="checkbox"/>	#1	<input type="checkbox"/>	#2	<input type="checkbox"/>	#3	<input type="checkbox"/>	#4
			Hep B	<input type="checkbox"/>	#1	<input type="checkbox"/>	#2	<input type="checkbox"/>	#3		
			MMR	<input type="checkbox"/>	#1						
			VAR	<input type="checkbox"/>							
<i>SUBJECTIVE</i>											
<i>OBJECTIVE</i>											
HEIGHT	WEIGHT		BLOOD PRESSURE			HR	RR				
	NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL	Describe Physical findings				
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Head	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
EOM	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
ENT	<input type="checkbox"/>	<input type="checkbox"/>	Neuro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Chest	<input type="checkbox"/>	<input type="checkbox"/>									
<i>ASSESSMENT</i>											
<i>PLAN</i>											
Provider's Signature					ANTICIPATORY GUIDANCE						
Provider's Stamp					Next Appointment						
					Sexual curiosity-normal			<input type="checkbox"/>			
Date					Read to children			<input type="checkbox"/>			
					Toilet training			<input type="checkbox"/>			
Date					Dental appointment			<input type="checkbox"/>			
					PPD			<input type="checkbox"/>			
Date					Skin protection-sun screen			<input type="checkbox"/>			
					LABS			<input type="checkbox"/>			
Date					Hgb/Hct _____						
					O&P _____						
DETAINEE LABEL											