Nassau County Department of Health
EARLY INTERVENTION PROGRAM

HEALTH STATUS REPORT

In compliance with the New York State Early Intervention Regulations Section 69-4.8(4)(I)(a), a physical examination is required as part of the initial multidisciplinary evaluation including a routine vision & hearing screening.

Child's Name _____ SEX: F M Date of Birth _____/_____/_____

Birth Weight: _____ Place of Birth: _____

Significant Family Medical/Social History (Explain)

Vision_____ Hearing_____

TB _____Chronic Illnesses_____

Social Concerns: _____

Exposure to Violence: _____

High Risk Birth/Complications: _____

Complete Physical Examination

Date of Examination: _____/_____/_____

Height: _____ Weight: _____Percentile: _____

Head Circumference: _____ B / P : _____/_____

Nutritional Concerns:_____

Current Medications:_____

IMMUNIZATION HISTORY
DATE IMMUNIZATION GIVEN

	1st	2nd	3rd	4th	5th
HEP B					
DTP					
HIB					
POLIO					
MMR					
VARICELLA					
PNUMOCOCCAL					
INFLUENZA					
HEPATITIS A					

ALLERGIES

- ☐ None
- ☐ Food_____
- ☐ Medicine_____
- ☐ Other_____

LEAD TEST HISTORY

	DATE	RESULT
ONE YEAR		
TWO YEARS		
OTHER		

DEVELOPMENTAL OBSERVATIONS – Please complete for each age level by placing a check in each area. Indicate any action or follow-up necessary.

BY 6 MONTHS:
____Imitates vocalizing
____Turns to voice
____Rolls over
____Reaches (ea. Hand)
____Cuddles

____AVOIDS EYE CONTACT

BY 12 MONTHS:
____Stands alone 2 secs.
____Bangs two blocks
____Says "Mama/Dada" specifically
____Responds to "no"
____Plays patty cake or waves "bye-bye"

____AVOIDS EYE CONTACT

____CONCERN THAT CHILD CAN'T HEAR

____TUNES OUT

BY 18 MONTHS:
____Imitates household chores (sweeping)
____Says 4 words besides "Mama/Dada"
____Points to one body part "show me your nose"
____Drinks from a cup
____Scribbles

____AVOIDS EYE CONTACT

____TOE WALKING

BY 2 YEARS:
____Kicks ball forward
____Combines 2 words
____Strangers understand half child's speech
____Points to 6 named body parts (nose, eyes…)
____Names 1 animal picture
____Takes off clothing (other than hat)

PERSISTENT:
____ROCKING

____HEADBANGING

BY 3 YEARS:
____Holds 2-3 sentence conversation
____Names 4 animal pictures
____Knows 2 animal actions -flies, meows?
____Understands what to do when tired, cold or hungry (1 of 3)
____Imitates vertical line

____Washes & dries hands
____ECHOLALIA (repeating what was just said)
____HANDFLAPPING

PARENTAL CONSENT TO OBTAIN/RELEASE INFORMATION

Child's Name:_____ Date of Birth:____/____/____

I, _____, give my consent to have my child's records released to
Name of Parent/Guardian (Please Print)

Nassau County Department of Health Early Intervention Program.

_____ _____
Signature of Parent/Guardian Date

PHYSICIAN RECOMMENDATIONS & REFERRALS

Please indicate which of the medical specialty areas this child has visited or been referred:

	Referred	Date Visited
Developmental Pediatrician	_____	_____
Visual/ Ophthalmologist	_____	_____
ENT/Hearing	_____	_____
Neurologist	_____	_____
Cardiologist	_____	_____
Orthopedist/ Physiatrist	_____	_____
Neo-Natal Spec.	_____	_____
Gastro-Intestinal	_____	_____
Genetic Testing	_____	_____
Audiological	_____	_____
Physical Thpy.	_____	_____
Occupational Thpy:	_____	_____
Speech Thpy.	_____	_____

CLINICAL IMPRESSIONS & RECOMMENDATIONS

Indicate all chronic conditions and/or findings needing follow-up:

1. _____

2. _____

DIAGNOSIS & ICD 10 CODE:

_____

_____

This child is being referred because he/she is suspected of having a disability, which includes a developmental delay and/or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

_____
Physician Signature

Print Name_____

Address_____

_____

Phone No._____

License No._____

Physician NPI No._____