	INFANCY						
●- To be performed S- Subjective by history O- Objective by testing A- At risk Δ- If not performed at school	NEW BORN INPT	1 WEEK Optional	By 1 MONTH	2 MONTH	4 MONTH	6 MONTH	9 MONTH
HISTORY							
Initial/Interval	●	●	●	●	●	●	●
MEASUREMENTS							
Height and Weight	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●
Blood Pressure							
BMI							
SENSORY SCREENING							
Vision	●	S	●	●	●	O	<-----O----->
Hearing	●	S	S	S	S	S	S
DEVELOPMENTAL / BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●
PROCEDURES - GENERAL							
Hereditary / Metabolic Screening	●	Test if not previously tested					
Immunization	●	●	●	●	●	●	●
Hematocrit or Hemoglobin							<------●---->
Urinalysis							
PROCEDURES - PATIENTS AT RISK							
Lead Screening						S	<-----●----->
Tuberculin Test							
Cholesterol Screening							
STD Screening							
Pelvic Exam							
ANTICIPATORY GUIDANCE							
Injury Prevention	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●
Sleep Positioning Counseling	●	●	●	●	●	●	●
Nutrition Counseling	●	●	●	●	●	●	●
DENTAL REMINDER							