Head Start
Early Head Start

PHYSICAL EXAMINATION

CHILD'S LEGAL NAME: ____ DOB: ___________________ SEX: _____

(TO BE COMPLETED BY THE HEALTH CARE PROVIDER)

DATE OF EXAMINATION: _______________

****LABORATORY TESTS REQUIRED FOR HEAD START/EARLY HEAD START**:**

Hemoglobin/Hematocrit: _______________ **Date of Laboratory test:** _______________________

Blood Lead Level (required at 12 and 24 months): 12 month:_________ Date: __________24 Month:_________ Date:________

OTHER LABORATORY TESTS AS INDICATED FOR MEDICAL ASSESSMENT:
Sickle Cell Anemia:__________ Tuberculin Test Date:__________ Result:__________
Other (specify):____

SCREENINGS: Newborn Hearing Screen: Pass______ Fail______ **Hearing Screen: Pass______ Fail_______**
B/P:__________
Screening tool used:____________________
HT: __________ Head Circumference:_______
Vision Screen: Pass_______ Fail_______
WT:__________ BMI:__________
Screening tool used:____________________
Social Emotional Screen Date: __________Score ______ Cutoff___*Attach copy

EXAMINATION: (N) indicates **NORMAL (AB)** indicates **ABNORMAL**

General Appearance:	Dental Observation:	Extremities:
Skin:	Neck (glands):	Genito-Urinary:
Head:	Chest:	Physical Development:
Eyes:	Heart:	Mental Development:
Ears:	Lungs:	Neurological:
Nose, Throat, Mouth:	Abdomen:	Speech:

Explain any abnormal findings: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

___ Yes ___ No Was Fluoride Varnish applied during this visit?
___ Yes ___ No Was a Lead Screening Questionnaire completed with this child's parent?
___ Yes ___ No is this child up to date on well-child visits?
___ Yes ___ No is this child (if age is 0-36 months) up to date on oral health care/anticipatory guidance?
___ Yes ___ No is this child up to date on immunizations? (*Attach immunization record)
___ Yes ___ No is this child receiving treatment for a chronic condition?

If yes, check all that apply:

____ Anemia ____ High Lead Levels ____Asthma ____ Sickle Cell ____ Diabetes
____ Vision Problems ____ Hearing Problems ____ Overweight ____ Underweight
____ Seizures ____ Low Birth Weight ____ Other: ____

Are there any restrictions in activity, recommendation for follow-up, or referrals? ________________________________

HEALTH CARE PROVIDER (please print name):____

CLINIC / ADDRESS: ____ Phone: _________________

SIGNATURE OF HEALTH CARE PROVIDER: ______________________________________ **DATE:** _____________

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