ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD TESTS FOR LEAD and HEMOGLOBIN. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

EARLY HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

CHILD'S NAME	DATE OF BIRTH	CENTER

WELL CHILD EXAM PERFORMED TODAY (PLEASE CHECK ONE)

☐ <1 mo ☐ 2 mos ☐ 4 mos ☐ 6 mos ☐ 9 mos ☐ 12 mos ☐ 15 mos ☐ 18 mos ☐ 24 mos ☐ 30 mos

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM

ADDRESS

EXAMINATION RESULTS

HEIGHT ____ inches | WEIGHT ____ lbs/oz | HEAD CIRCUMFERENCE *(Required up to 24 months of age)* ____ centimeters

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth/Teeth/			Abdomen		
Head			Oral Health Assessment			Genitalia		
Neck			Throat			Neurologic		
Lymph Nodes			Chest			Extremities		
Eyes			Lungs			Motor Ability		
Ears			Heart			Psychological		
Nose			Back			Speech		

Sensory Screenings (Clinical Assessments)

VISION ASSESSMENT ☐ Normal ☐ Abnormal

HEARING ASSESSMENT ☐ Normal ☐ Abnormal

Immunizations

IMMUNIZATIONS GIVEN TODAY

☐ Hepatitis B ☐ DTaP ☐ PCV ☐ Rotavirus
☐ MMR ☐ Polio ☐ Hib
☐ Influenza ☐ Varicela ☐ Hepatitis A

Hemoglobin (Required at 12 months)

DATE	HGB(g/dl)	
		☐ No Risk Anemia

TREATMENT ☐ Anemia ☐ Iron Prescribed

DATE OF FOLLOW-UP APPOINTMENT

Lead

DATE	LEAD LEVEL @ 12 MOS. mcg/dL
DATE	LEAD LEVEL @ 24 MOS. mcg/dL

Medicaid requires a lead test at 12 and 24 months.

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ

DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE

Lead Risk Assessment

☐ At Risk ☐ No Risk

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		
Dental Screening		

Diagnosis/Abnormal Findings

Treatment/Restrictions/Recommendations for School

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL

☐ Yes ☐ No **(If yes, Medication Administration form needed)**

TYPE OF MEDICATION AND PURPOSE

Child is physically and emotionally able to participate in program

☐ Yes ☐ No ***(If no, please explain in space above)***

7/18 **Distribution:** **White – Child's File** **Canary – Parent** Form 077

G:/Forms-New/Health-Nurition-Safety/EHS-Health/077EarlyHeadStartPhysicalExamNCR.doc

Date Received Completed Physical Form:_____ **Staff Name:**_____