HEAD START PHYSICAL EXAM FORM

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Early Head Start requires a COMPLETE HEALTH EXAM, including BLOOD TESTS FOR LEAD and HEMATOCRIT. 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 or fax to the number above.

CHILD'S NAME			DATE OF BIRTH
Physical Exam performed today (Please check one)	**3yr ☐**	**4yr ☐**	**5yr ☐**

HEALTH CARE PROVIDER INFORMATION

PHYSICIAN NAME	SIGNATURE (Required)	
CLINIC/TYPE OF PRACTICE	TELEPHONE	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

Height: _____ inches	Weight: _____ lbs. _____ oz.	BP: _____ / _____	BMI _____%

EXAM	*Results:*	EXAM	*Results:*	Sensory Screening
Skin	☐ Normal ☐ Abnormal	**Genitalia**	☐ Normal ☐ Abnormal	**VISION ASSESSMENT**
EENT	☐ Normal ☐ Abnormal	**Neurologic**	☐ Normal ☐ Abnormal	Right / Left /
Lymph Nodes	☐ Normal ☐ Abnormal	**Motor Ability**	☐ Normal ☐ Abnormal	☐ Pass ☐ Refer
Heart	☐ Normal ☐ Abnormal	**Emotional**	☐ Normal ☐ Abnormal	**HEARING ASSESSMENT**
Lungs	☐ Normal ☐ Abnormal	**Social**	☐ Normal ☐ Abnormal	Right: ☐ Pass ☐ Refer
Musculoskeletal	☐ Normal ☐ Abnormal	**Speech**	☐ Normal ☐ Abnormal	Left: ☐ Pass ☐ Refer
Abdomen	☐ Normal ☐ Abnormal	**Behavioral**	☐ Normal ☐ Abnormal	

Anemia Testing (12 mos.)	Lead (12 and 24 mos)	Immunizations
DATE: _____ HEMOGLOBIN _____(g/dL) **OR** DATE: _____ HEMATOCRIT _____% ☐ No Risk ☐ Refer	DATE: _____ LEAD LEVEL @ 12 mos. (mcg/dl): _____ ☐ No risk ☐ Refer DATE: _____ LEAD LEVEL @ 24 mos. (mcg/dl): _____ ☐ No risk ☐ Refer	☐ Up to Date ☐ Deferred/Exempt Immunizations Given Today (if applicable): ☐ Hepatitis B ☐ DTaP ☐ PCV ☐ Rotavirus ☐ MMR ☐ Polio ☐ Hib ☐ Varicela ☐ Hepatitis A ☐ Influenza ☐ COVID

Chronic Disease Assessment

Does the child have allergies? ☐ No ☐ Yes (please list) Epipen required? ☐ No ☐ Yes

Is medication required at school? ☐ Yes ☐ No (If yes, Authorization to Administer Medication form will need to be completed by provider)

Does this child need treatment or have recommendations for school? ☐ No ☐ Yes (please explain)

For Program Use Only:	
Date Received:	*Received By:*