ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM. Documentation of ALL screenings are 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.

Center: _____

Child's Name: _____ Date of Birth: _____

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

Periodicity visit for: 1-2 Mos | 3-4 Mos | 5-6 Mos | 7-9 Mos | 10-12 Mos | 13-15 Mos | 16-23 Mos | 2 Yr | 3 Yr | 4 Yr | 5 Yr

Examination Date: _____ Practice/Clinic Name: _____

Provider (Please Print): _____ Address: _____

Signature: _____ Phone Number: _____

Height: (%)		**Weight: (%)**		**Blood Pressure:**		**Head Circumference:**		
Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested	
General Appearance				Eyes				
Posture, Gait				Ears				
Speech				Genitalia				
Head/Neck				Muscular Coordination				
Skin				Motor Ability				
Mouth/Teeth				Self-help/Social Skills				
Heart				Communication Skills				
Lungs				Cognitive Skills				
Abdomen (Hernia)				**Allergies (List):**				

LABORATORY

Hematocrit/Hemoglobin	Date:	Results:	**Immunizations Given This Visit:**				
Lead	Date:	Results:	❑ Polio	❑ DTP/DTaP	❑ MMR	❑ HepB	❑ HIB
Sickle Cell	Date:	Results:	❑ Other (List):				
Urinalysis	Date:	Results:	Next Shots Due/Date:				
Tuberculin Skin Test	Type:	Date of Test:	Date Read:	Results: ❑ Negative ❑ Positive	Rx Date:	Chest X-ray Date:	Results: ❑ Negative ❑ Positive

VISION Date:		**HEARING** Date:				
Acuity - Right Eye:	/	Frequency	1000	2000	3000	4000
Acuity - Left Eye:	/	Right Ear	dB	dB	dB	dB
Strabismus:		Left Ear	dB	dB	dB	dB

Findings, Treatments & Recommended Follow-up:

List Medications: