

### 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				
<b>WELL CHILD EXAM PERFORMED TODAY (PLEASE CHECK ONE)</b> <input type="checkbox"/> <1 mo <input type="checkbox"/> 2 mos <input type="checkbox"/> 4 mos <input type="checkbox"/> 6 mos <input type="checkbox"/> 9 mos <input type="checkbox"/> 12 mos <input type="checkbox"/> 15 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 24 mos <input type="checkbox"/> 30 mos										
<b>HEALTH CARE PROVIDER INFORMATION</b>										
PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)						SIGNATURE				
CLINIC/TYPE OF PRACTICE			TELEPHONE NUMBER			DATE OF EXAM				
ADDRESS										
<b>EXAMINATION RESULTS</b>										
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/ Oral Health Assessment				Abdomen		
Head								Genitalia		
Neck				Throat				Neurologic		
Lymph Nodes				Chest				Extremities		
Eyes				Lungs				Motor Ability		
Ears				Heart				Psychological		
Nose				Back				Speech		
<b>Sensory Screenings (Clinical Assessments)</b>						<b>Immunizations</b>				
VISION ASSESSMENT <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			HEARING ASSESSMENT <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			IMMUNIZATIONS GIVEN TODAY <input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> PCV <input type="checkbox"/> Rotavirus <input type="checkbox"/> MMR <input type="checkbox"/> Polio <input type="checkbox"/> Hib <input type="checkbox"/> Influenza <input type="checkbox"/> Varicela <input type="checkbox"/> Hepatitis A				
<b>Hemoglobin (Required at 12 months)</b>						<b>Lead</b>				
DATE		HGB(g/dl)		<input type="checkbox"/> No Risk Anemia		DATE		LEAD LEVEL @ 12 MOS. mcg/dL		
TREATMENT <input type="checkbox"/> Anemia <input type="checkbox"/> Iron Prescribed			DATE OF FOLLOW-UP APPOINTMENT			DATE		LEAD LEVEL @ 24 MOS. mcg/dL		
<b>Screening of TB Risk Factors</b>						<b>Lead Risk Assessment</b>				
<input type="checkbox"/> Risk factors NOT present: TB SKIN TEST NOT REQUIRED <input type="checkbox"/> Risk factors present: Mantoux TB skin test performed						<input type="checkbox"/> At Risk <input type="checkbox"/> No Risk				
DATE GIVEN		RESULTS mm		DATE READ		Provided		Yes	No	
		<input type="checkbox"/> Non Significant <input type="checkbox"/> Significant				Anticipatory Guidance Provided				
DATE OF CHEST X-RAY		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		RX DATE		Fluoride Varnish Applied				
						Dental Screening				
<b>Diagnosis/Abnormal Findings</b>						<b>Treatment/Restrictions/Recommendations for School</b>				
Does the child have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No										
MEDICATIONS REQUIRED AT SCHOOL <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Medication Administration form needed)						Child is physically and emotionally able to participate in program <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain in space above)				
TYPE OF MEDICATION AND PURPOSE										