ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. 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.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE 3 Yr ☐ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER

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	WEIGHT	BLOOD PRESSURE
inches	lbs/oz	

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

Vision Acuity		Right	Left	Both	Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date		/	/	/	Date		1000 Hz	dB	dB
							2000 Hz	dB	dB
Test Type					Test Type		3000 Hz	dB	dB
							4000 Hz	dB	dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 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			DATE READ
	mm	☐ Non Significant	☐ Significant	

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

Lead Risk Assessment

☐ At Risk ☐ No Risk

Immunizations

GIVEN TODAY

☐ Yes ☐ No List:_____

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

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)**

Child is physically and emotionally able to participate in program

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

TYPE OF MEDICATION AND PURPOSE

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

Form #78 Head Start Physical Exam (NCR)

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