Division of Early Learning Services
CHILD DEVELOPMENT PROGRAMS

Physical Examination/Well BabyCheck

Child's Name: ______________________ Date of Physical Examination: ______________

Date of Birth: ______________________

Head Start requires a complete CHDP equivalent health examination for entrance into the program.

CHDP Periodicity visit for: 3 Yrs. 4 Yrs. 5 Yrs.

TB Risk Factor Assessment: ❑ Risk factors not present; TB skin test not require

Hematocrit/Hemoglobin:	Date:	Results:	Anemia: ❑ Yes ❑ No	Iron Supplements: ❑ Yes ❑ No	
Blood Lead Test: 12 or 24 Month. **If no record, perform**	Date:	Results:	Blood Pressure:	Date:	Results:____/ _____
Tuberculin Skin Test	Date Given:	Date Read:	Results: ☐ Negative ☐ Positive	Chest X-ray Date:	Results: ☐ Negative ☐ Positive

Height: (%)	Weight: (%)	BMI:	Head Circumference:
Vision: Right – 20/________ Left – 20/ ________		Strabismus: ❑ Pass ❑ Fail	Hearing: ❑ Pass ❑ Fail

Examination Results	Normal for age	Abnormal (describe findings)	Not Tested	Examination Results	Normal for age	Abnormal (describe findings)	Not Tested
Anticipatory Guidance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Developmental Screening			
Ears/Nose/Throat				Autism Spectrum Disorder Screening (18 and 24 mos)			
Seizures				Developmental Surveillance			
Mouth/Teeth Dental/Nutrition				Psychosocial/Behavior Assessment			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (hernia)				Maternal Depression Screening			

Is the child cleared to enter preschool? ❑ **Yes** ❑ **No**

List any allergies, chronic conditions or special accommodations: ______________________________

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1. Required Medication to be given at school: Start Date: ______________ Stop Date: ______________

Medication: ______________________ Dosage: ______________________

Frequency: ______________________________

Symptoms indicating when to use: ______________________________

Parent Signature Required for Administration of Medication: ______________________ **Date/Fecha:** ____________

Possible reactions or side effects: ______________________________

Provider (please print): ______________________ **Provider Signature:** ______________________

Practice/Clinic Name: ______________________ Phone Number: ______________________

Address: ______________________________