PREVENTATIVE HEALTH CARE EXAMINATION FORM – INITIAL ENTRY (PRESCHOOL/HEAD START)

(To Be Completed By Physician Conducting The Examination)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ **Date of Birth** _____

Parent or Guardian Name _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM

MEDICAL HISTORY

Seizures: _____

Chronic Illnesses: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

_____

PHYSICAL EXAM:

Normal	Abnormal		
_____	_____	General Appearance	Height: _____ Weight: _____
_____	_____	HEENT	Hearing: R: _____ L: _____
_____	_____	Skin	Vision: R: _____ L: _____
_____	_____	Neck	Blood Pressure: _____
_____	_____	Chest	STRABISMUS/AMBLYOPIA SCREEN ____Abnormal
_____	_____	Heart	Optional: HCT/HGB :_____(required for Head start)
_____	_____	Genitalia	Optional: UA: _____
_____	_____	Extremities – Back	Lead_____(required for Head Start)
_____	_____	Neuro	

Explain abnormal exam: _____

_____

Recommendations: _____No Restrictions/Normal Exam

_____Restrictions and suggestions to school: _____

_____

Age appropriate and suggested anticipatory guidance (health assessments):

- € ___Discuss injury prevention with parents:
- □ Bicycle Safety € Car Seat Belts € Memorization of Name, Address, and Phone Number
- □ Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers
- € ___Emphasize the importance of dental care
- € ___Discuss mental health issues

Signed: _____ **Date:** _____

(Physician/ARNP/PA/EPSDT Provider)

Address: _____ **Phone #:** _____