PHYSICAL

DELAWARE COUNTY INTERMEDIATE UNIT
HEAD START
PHYSICAL FORM

Section I - To be Completed by Parent/Guardian		
Child's Name *(Last)* *(First)*	Gender ❑Male ❑ Female	Date of Birth
Parent/Guardian Name	Telephone Number	Center Location
I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns.		
Parent/Guardian Signature	*Date*	

Section II – To be Completed by Health Care Provider			
Date of Exam	Health history pertinent for routine child care including allergies, asthma, seizure disorders and special needs: ❑ None		
Height	Weight	Hearing	Vision
Lead	Hemoglobin	TB	Sickle Cell ❑ Yes ❑ No

****ALL IMMUNIZATIONS ACCORDING TO EPSDT MUST BE LISTED BELOW INCLUDING THE INFLUENZA VACCINE.****

Immunizations	Date	Date	Date	Date	Date
Polio					
DTAP/DTP					
MMR					
Varicella					
Influenza					
HIB					
Hep B					
Hep A					
PCV					
Rotavirus					

Physical Examination	**Normal**	**Abnormal (Comments)**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (E.G.DDST)		

Please Print/Stamp	
Medical Provider: **Address:** **Phone Number:**	Next Physical Appt. Date: _____ Next Dental Appt. Date: _____ _____ ***Provider Signature*** ***Date***

Please attach any plans of care to this form

Revised 10/13/17 MC