

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			
WELL CHILD EXAM PERFORMED TODAY (PLEASE CHECK ONE) <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									
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 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/				Abdomen		
Head			Oral Health Assessment				Genitalia		
Neck			Throat				Neurologic		
Lymph Nodes			Chest				Extremities		
Eyes			Lungs				Motor Ability		
Ears			Heart				Psychological		
Nose			Back				Speech		
Sensory Screenings (Clinical Assessments)					Immunizations				
VISION ASSESSMENT			HEARING ASSESSMENT			IMMUNIZATIONS GIVEN TODAY			
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			<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			
Hemoglobin (Required at 12 months)					Lead				
DATE	HGB(g/dl)			<input type="checkbox"/> No Risk Anemia			DATE	LEAD LEVEL @ 12 MOS. mcg/dL	
TREATMENT			DATE OF FOLLOW-UP APPOINTMENT			DATE	LEAD LEVEL @ 24 MOS. mcg/dL		
<input type="checkbox"/> Anemia <input type="checkbox"/> Iron Prescribed						Medicaid requires a lead test at 12 and 24 months.			
Screening of TB Risk Factors					Lead Risk Assessment				
<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				
					Provided		Yes	No	
DATE GIVEN					RESULTS				
					mm				
					<input type="checkbox"/> Non Significant <input type="checkbox"/> Significant		DATE READ		
DATE OF CHEST X-RAY					RX DATE				
					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Diagnosis/Abnormal Findings					Treatment/Restrictions/Recommendations for School				
Does the child have asthma?									
<input type="checkbox"/> Yes <input type="checkbox"/> No									
MEDICATIONS REQUIRED AT SCHOOL					Child is physically and emotionally able to participate in program				
<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Health Plan Needed & Medication Administration form needed)					<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain in space above)				
TYPE OF MEDICATION AND PURPOSE									

Effective 03/01/2023



Date Received Completed Physical Form: _____

Staff Name: _____