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
feet inches	lbs oz	/ ☐ Unable to obtain

EXAM	Normal	Abnormal		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
Date		/	/	/
Test Type				

Hearing Screening	
Date	TestType
Result ☐Normal ☐Abnormal	Treatment

Frequency (Hz)	Right (db)	Left (db)
1000 Hz		dBdB
2000 Hz		dBdB
3000 Hz		dBdB
4000 Hz		dBdB

Hemoglobin

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

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

Lead

DAE	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, Health Plan Needed & 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

Effective 03/01/2023

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