Name of School:_____

Region 14/15 Education Service Center
Early Head Start/Head Start - Physical Exam

Early Head Start and Head Start Programs are required to obtain a statement from a healthcare professional determining whether a student is up-to-date on a schedule of age appropriate preventive and primary medical care. The Texas Health Steps Periodicity Schedule is utilized to determine age appropriate care and treatment.

Date of Exam:____/____/_____ **Name:**_____ **DOB:**_____

Ht:_____ **Wt:**_____**BP (3-5 years):**_____ **Head Circ. (0-24 months):**_____ **AGE:** _____

BMI (2 years and older): ___ *Underweight (<5th percentile) ___ Healthy (5th - 84th%)
___ *Overweight (85th - 94th percentile) ___ *Obese (95th percentile or above)

Vision Screen: Pass Fail If failed, Referral to:_____ Date:_____ Time:_____

Hearing Screen: Pass Fail If failed, Referral to:_____ Date:_____ Time:_____

Mandatory EPSDT Labs: (Tx DSHS Childhood Blood Lead Screening Guidelines **require blood lead testing for all children (Medicaid or Private insurance)** in our area due to living in targeted zip codes)

Lead Levels: **12 Month** - Date:_____ Result:_____ **24 Month** - Date:_____ Result:_____

Anemia Testing: **12 Month** Hemoglobin - Date:_____ Result:_____ or Hematocrit - Date: _____ Result:_____

Lab work drawn/collected today? Yes No If "Yes", what labs?_____ **TB screening?** _____

Has this child ever been diagnosed with any of the following chronic conditions? Autism____ ADHD____

Lead levels >5 µg/dL___ Asthma___ Diabetes___ Seizures___ Vision Problems___ Hearing Problems___

Life-threatening allergies (e.g. food, bee stings, and medication that may result in systemic anaphylaxis)____

Medical Information	Instructions or modifications for care while in school
Allergies:	
Medical Conditions/Diagnosis:	
Current Medication(s):	

Needs Medical Treatment? Yes No Explain_____

Treatment Received? Yes No Explain_____

Referral and/or follow-up needed? Yes No Explain_____

Immunizations: Up-to-Date (provider copy)_____ Deferred_____ Follow up appt: _____

This child is up-to-date on a physical exam based on the Texas Health Steps EPSDT Schedule and is able to take part in day care/school program activities.

Provider Signature_____ **Date**_____/_____/_____

Address_____ **Phone**_____

Next Appointment Date_____ **Time**_____

Head Start Use Only: Date received_____**Initial**_____