

EARLY HEAD START PHYSICAL/WELL CHILD EXAMINATION

Child's Name _____ Birth Date _____
 Parents/Guardians _____
 Address _____

I authorize the provider listed below to release this form to the G-K-B Early Head Start. _____

(*Parent/Guardian Signature & Date*)

Immunization Record

Printed Report Attached

DtaP #1 _____ #2 _____ #3 _____ #4 _____ #5 _____
 IPV #1 _____ #2 _____ #3 _____ #4 _____ #5 _____
 HIB #1 _____ #2 _____ #3 _____ #4 _____
 PCV #1 _____ #2 _____ #3 _____ #4 _____
 HEP B #1 _____ #2 _____ #3 _____
 MMR #1 _____ #2 _____
 Varicella #1 _____ #2 _____
 HEP A (Recommended) #1 _____ #2 _____
 Rotovirus (Recommended) #1 _____ #2 _____ #3 _____
 Influenza (Recommended Yearly) #1 _____ #2 _____

Disease History

Allergies, Please List: _____
 If yes, give date(s): Asthma _____, Chicken Pox _____ Hospitalizations/Surgeries: _____

Medical Examination

MEASUREMENTS: Height _____ Weight _____ Head Circumference (Up to Age 2) _____ BP (3 or > Years) _____

| <input type="checkbox"/> Printed Report Attached | Normal | Abnormal | Referral | Comments | |
|--|--------|----------|----------|----------|---|
| General Appearance | | | | | <div style="background-color: yellow; padding: 2px;">LAB WORK: *See Back Side**</div> <div style="background-color: yellow; padding: 2px;">**REQUIRED AT 9-12 & 24 MONTHS**</div> <div style="background-color: yellow; padding: 2px;">Lead Level: _____</div> <div style="background-color: yellow; padding: 2px;">HGB/HCT: _____</div> <div style="background-color: yellow; padding: 2px;">SICKLE CELL ANEMIA</div> <div style="background-color: yellow; padding: 2px;">(If Applicable): _____</div> <p>Does this child have any health conditions that would be hazardous to him/herself or to other children? YES ___ NO ___ If yes, what modifications would be necessary to protect child and his/her classmates?</p> <p>Have you prescribed any medication or special routines which should be included in the center's plan for this child's activities? YES ___ NO ___ If yes, what medications or special routines?</p> <p>Is this child considered up-to-date with his/her health care and immunizations according to EPSDT & CDC? YES ___ NO ___</p> |
| Behavior Assessment | | | | | |
| Heart | | | | | |
| Neck | | | | | |
| Chest | | | | | |
| Cardiovascular | | | | | |
| Abdomen | | | | | |
| Genitalia | | | | | |
| Neurological Exam | | | | | |
| Skin | | | | | |
| Oral/Dental Screen | | | | | |
| Developmental Progress | | | | | |
| Hearing | | | | | |
| Vision | | | | | |
| Speech | | | | | |

ADDITIONAL COMMENTS, CONCERNS, PLANS, FOLLOW UP: _____

Physician's Printed Name: _____ **Date of Exam:** _____
Physician's Signature: _____ **Phone Number:** _____

RETURN FORM TO G-K-B HEAD START & EARLY HEAD START - 504 S. Second St. Garrett, IN 46738, or FAX to 260-357-3044