

HEAD START PHYSICAL EXAMINATION

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

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

(*Parent/Guardian Signature & Date*)

Immunization Record

Printed Report Attached

DtaP #1 _____ #2 _____ #3 _____ #4 _____ #5 _____
 IPV #1 _____ #2 _____ #3 _____ #4 _____
 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 _____
 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 _____ 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;">URINALYSIS (*Required at Age 5): _____</div> <div style="background-color: yellow; padding: 2px;">HGB/HCT (*Required at Age 5): _____</div> <div style="background-color: yellow; padding: 2px;">LEAD: Has this child ever had a lead test? Yes -or- No If yes, give date and results _____</div> <div style="background-color: yellow; padding: 2px;">If no, labs need ordered. Date & Results: _____</div> <div style="background-color: yellow; padding: 2px;">SICKLE CELL ANEMIA (If applicable): _____</div> <div style="padding: 2px;">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?</div> <div style="padding: 2px;">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?</div> <div style="padding: 2px;">Is this child considered up-to-date with his/her health care and immunizations according to EPSDT & CDC? YES ___ NO ___</div>
Behavior Assessment					
Heent					
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