

Head Start Physical Examination



Child's Name:	Center/Class:
Parent's Name:	Child's Birthdate:

PROVIDER INFORMATION	
Provider Name:	Phone Number: () -
Clinic Name (if different):	Fax Number: () -
Clinic Address:	
City/State/Zip code:	

SECTION 1 - PHYSICAL ASSESSMENT	Normal	Abnormal	Refer	Not Examined
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes External Aspects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears External Canal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen (include hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bones, joints, muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glands (Lymphatic/Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Conditions/Disabilities: _____				
Asthma/Allergies(specify): _____				
Current Medications: _____				
Medications Prescribed: _____				

SECTION 2 - CHILD HEALTH STATUS	YES	NO
1. Child is up-to-date on a schedule of age appropriate preventative and primary health care.	<input type="checkbox"/>	<input type="checkbox"/>
2. Child needs to establish the following services:		
Well Child Care	<input type="checkbox"/>	
Immunizations Update	<input type="checkbox"/>	
Routine Dental Care	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	
3. Child has Acute or Chronic Condition(s) and is:	<input type="checkbox"/>	<input type="checkbox"/>
(a) receiving adequate ongoing care	<input type="checkbox"/>	<input type="checkbox"/>
(b) needs to establish services	<input type="checkbox"/>	<input type="checkbox"/>
(c) needs to update or re-establish services	<input type="checkbox"/>	<input type="checkbox"/>
4. Child has suspect or significant undiagnosed/untreated problems.	<input type="checkbox"/>	<input type="checkbox"/>
Explain: _____		
5. Child's status was determined by:		
Parent report	<input type="checkbox"/>	
Medical history	<input type="checkbox"/>	
Today's exam	<input type="checkbox"/>	

SECTION 3 - Standard Tests & Measurements			
Blood Pressure _____/_____	Normal	Abnormal	HGB _____ or HCT _____ (fingerprick)
Height _____' _____"	<input type="checkbox"/>	<input type="checkbox"/>	Urine _____
Weight _____ lbs. _____ oz.	<input type="checkbox"/>	<input type="checkbox"/>	Other Labs as authorized: _____
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Normal
			Abnormal

General impression of child's current health condition:

Good

Follow-up or Referral Comments: _____

Health Professional's Signature: _____ Date: _____

I hereby authorize the release of any information from a Head Start related exam or followup be released to SUU Head Start for my enrolled child for the current school year.	
Parent/Guardian Signature: _____	Date: _____