**ATTENTION PROVIDER:**

*Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM. Documentation of ALL screenings are 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.*

SITE: 🞎 Morey 🞎 Oakdale 🞎 Rio Linda 🞎 Village

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)**

Periodicity visit for: 1-2 3-4 5-6 7-9 10-12 13-15 16-23 2 3 4 5

 Mos Mos Mos Mos Mos Mos Mos Yr Yr Yr Yr

Examination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice/Clinic Name:

Provider Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Height: ( %)**  | **Weight: ( %)**  | **Blood Pressure:**  | **Head Circumference:**  |
| Examination Results  | Normal for Age  | Abnormal (Describe Findings)  | Not Tested  | Examination Results  | Normal for Age  | Abnormal (Describe Findings)  | Not Tested  |
| General Appearance  |   |   |   | Eyes  |   |   |   |
| Posture, Gait  |   |   |   | Ears  |   |   |   |
| Speech  |   |   |   | Genitalia  |   |   |   |
| Head/Neck  |   |   |   | Muscular Coordination  |   |   |   |
| Skin  |   |   |   | Motor Ability  |   |   |   |
| Mouth/Teeth  |   |   |   | Self-Help/Social Skills  |   |   |   |
| Heart  |   |   |   | Communication Skills  |   |   |   |
| Lungs  |   |   |   | Cognitive Skills  |   |   |   |
| Abdomen (Hernia)  |   |   |   | **Allergies (List):**  |
| **LABORATORY**  |
| Hematocrit/Hemoglobin  | Date:  | Results:  | **Immunizations Given This Visit:**  |
| Lead  | Date:  | Results:  | 🞎 Polio  | 🞎 DTP/DTaP | 🞎 MMR  | 🞎 HepB  | 🞎 HIB  |
| Sickle Cell  | Date:  | Results:  | 🞎 Other (List):  |
| Urinalysis  | Date:  | Results:  | Next Shots Due Date:  |
| Tuberculin Skin Test  | Type:  | Date of Test:  | Date Read:  | Results: 🞎 Negative 🞎 Positive | Rx Date:  | Chest X-ray Date:  | Results: 🞎 Negative 🞎 Positive |
| **VISION**  Date:  | **HEARING**  Date:  |
| Acuity - Right Eye: /  | Frequency  | 1000  | 2000  | 3000  | 4000  |
| Acuity - Left Eye: /  | Right Ear  |  dB  |  dB  |  dB  |  dB  |
| Strabismus:  | Left Ear  |  dB  |  dB  |  dB  |  dB  |
| **Findings, Treatments & Recommended Follow-up:**  |
| **List Medications:**  |