HEAD START PHYSICAL EXAMINATION FORM

HEAD START STAFF USE ONLY:
DATE RECEIVED: ________________ INITIALS: _________

CHILD'S NAME: ____ SEX: ________ BIRTHDATE: __________________

HEAD START CENTER: ____ CLASS: ___________ PHONE: _____________________

REQUIREMENT	DATE OF SERVICE	RESULTS	REQUIREMENT	DATE OF SERVICE	RESULTS		
a. AGE AT TIME OF PHYSICAL		______Yrs. ______Mos.	d. HEARING RESULTS R/L				
b. HEIGHT (in inches)		_________________In.	e. VISION RESULTS R/L				
c. WEIGHT (to nearest ¼ lb)		________Lbs. _____oz.	f. LEAD TEST **(ON OR AFTER AGE 2)**		**NUMERICAL RESULTS**		
CHILD'S WEIGHT IS: ☐ Normal ☐ Overweight ☐ Underweight			g. TUBERCULOSIS TEST **(IF NEEDED)**	**DATE GIVEN**	**DATE READ**	**RESULTS**	

REQUIREMENT	NORMAL ✓	ABNORMAL ✓ NEW	ABNORMAL ✓ KNOWN
a. ANTICIPATORY GUIDANCE & HEALTH ED ***INCLUDING ORAL HEALTH ASSESSMENT**			
b. BLOOD PRESSURE (**Required at Age 3 & Older**)			
c. DEVELOPMENTAL SURVEILLANCE			
d. PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT			
e. TUBERCULOSIS RISK ASSESSMENT			
f. ANEMIA RISK ASSESSMENT			
g. DYSLIPIDEMIA RISK ASSESSMENT (**2 & 4-Year-Olds Only**)			
h. HEMATOCRIT or HEMOGLOBIN (**IF NEEDED**)			
i. DYSLIPIDEMIA TEST (**IF NEEDED**)			

PROVIDER'S STAMP

FOR ABNORMAL HCT/HGB OR DYSLIPIDEMIA TEST RESULTS, PLEASE COMPLETE BELOW:

TREATMENT PLAN	FOLLOW-UP DATE	DATE TX COMPLETED

j. ALLERGIES – **IF SO, TYPE OF ALLERGY**: ____

OTHER ABNORMAL FINDING/DIAGNOSIS	NEW? ✓	CHRONIC? ✓	TREATMENT PLAN	FOLLOW-UP DATE	DATE TX COMPLETED
a.					
b.					
c.					

COMMENT:

Provider's Signature: ____ **Date:** ____________________