HEAD START

Physical Exam

Head Start Center:_____

Child's Name:_____Birthdate:_____

Social Security Number:_____Sex: M ___ F ___

Address: _____Phone:_____

Dear Doctor: **Please Read**
This child is required to have a complete physical examination (health check). Please complete this Form, sign and date it, and send with the parent. Thank you.

Height: _____ Weight: _____ BP: _____

Vision: _____ _Hearing: _____Speech: _____

Do you suspect any physical, emotional, language delays or abnormalities? Please describe.

_____

_____

Hematocrit Results: _____Lead Results: _____

Region	Normal	Abnormal	Comments
Skin			
EENT			
Heart			
Lungs			
Abdomen			
Neuromuscular			
Genitalia			

Is child taking any prescribed medication? _____Yes _____ No. If yes, describe:

Type:_____Dosage:_____

Are there any dietary restrictions? _____Yes _____No. If yes, describe: _____

_____

IMMUNIZATION HISTORY

DTP	_____	_____	_____	_____	_____
OPV	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____

Physician/Clinic Name: _____Phone Number: _____

Address: _____

Date: _____Physician's Signature: _____