DELAWARE OPPORTUNITIES INC
35430 State Highway 10 Hamden, NY 13782

Head Start Child Physical Exam Form

Child's Name:_____ Date Of Birth:___/___/___ Date Of Exam:___/___/____

Address:_____ Center:_____

Please list or attach copy of child's immunization record. If child is on a "catch-up" schedule or is medically exempt from curtain immunizations, documentation MUST be sent to Head Start stating so.

DTAP							Other:	
IPV								
HIB								
PCV								
Hep B								
MMR								
VARICELLA								

TESTS

Lead Screening Dates (Required by NYS LAW)
- 1 Year ___/___/____ Result:_____
- 2 Years ___/___/____ Result:_____
- Other ___/___/____ Result:_____

Hematocrit • Date ___/___/___ Result:_____ At Risk □YES □NO
Hemoglobin •Date ___/___/___ Result:_____ At Risk □YES □NO
Urinalysis •Date ___/___/___ Result:_____ (5 year olds only)
Cholesterol •Date ___/___/___ Result:_____ At Risk □YES □NO

- Hearing Date:___/___/____ Result: R- ___dB L- ___dB
- Vision Date:___/___/____ Result: R- ___/20 L- ___/20

(Subjective results only per NYS EPSDT)
Corrective lenses? □ YES □ NO

- Height _____
- Weight _____
- BMI _____

Blood Pressure_____

HEALTH SPECIFICS (All questions must be answered by Healthcare Provider)

		Comments or specific instructions
1. Does child have any allergies? (Specify)	□ YES □ NO	
2. Does child have asthma/ RAD? (Specify if child needs medication at school)	□ YES □ NO	
3. Does child require any medications to be administered at school? (Specify order)	□ YES □ NO	
4. Is a special diet required?	□ YES □ NO	
5. Does this child have any hearing, visual, or dental conditions?	□ YES □ NO	
6. Does this child have any medical, developmental, behavioral conditions and/or delays? (ex. speech, fine, or large motor delays, ADHD, autism, etc.)	□ YES □ NO	

7. Has this child/parent received anticipatory guidance according to recommendations of the NYS EPSDT in the area of injury prevention?	☐ YES ☐ NO	
8. Has this child/parent received anticipatory guidance according to recommendations of the NYS EPSDT in the area of violence prevention?	☐ YES ☐ NO	
9. Has this child/parent received anticipatory guidance according to recommendations of the NYS EPSDT in the area of nutrition counseling?	☐ YES ☐ NO	
10. Is this child up-to-date on a schedule of age appropriate preventative and primary health care which includes immunizations, medical, dental, and mental health according to the NYS EPSDT schedule?	☐ YES ☐ NO	If No, is child on a catch-up schedule?
11. Does this child have any contagious or communicable disease?	☐ YES ☐ NO	
12. On the basis of my findings, this child is able to participate in the Head Start program?	☐ YES ☐ NO	
13. Is this child being referred to another physician or dentist?	☐ YES ☐ NO	

Summary of Physical Exam (Include special recommendations for Head Start Staff)

_____

_____

_____

_____

_____

_____ _____

Signature of Examiner Date

_____ _____

Please Print Name Title

_____ _____

Address Phone

Child's Name_____