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:**_____
- **Vision** **Date:**__/__/____ **Result:**_____

(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 received anticipatory guidance according to recommendations of the NYS EPSDT in the area of injury prevention?	**☐ YES ☐ NO**	
8. Has this child received anticipatory guidance according to recommendations of the NYS EPSDT in the area of violence prevention?	**☐ YES ☐ NO**	
9. Has this child 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)

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_____

_____

_____

_____

_____ _____

Signature of Examiner **Date**

_____ _____

Please Print Name **Title**

_____ _____

Address **Phone**