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)

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Signature of Examiner ____________________ Date ____________________

Please Print Name ____________________ Title ____________________

Address ____________________ Phone ____________________

Child's Name____________________