Delaware Opportunities Inc. Head Start Child Physical Exam Form

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

Address:_____ **Center:**_____

Please attach copy of child's immunization record.

Is this child on an immunization catch up schedule? ____ Yes ____ No If yes, immunization apt date?_____

Lead Screening (Required by NYS LAW)

● 1 Year ___/___/____ Result:_____ ● 2 Year ___/___/____ Result:_____
Date Last Lead Screening? _____ At Risk? □ YES □ NO

Is this child at risk for Tuberculosis? □ YES □ NO If Yes, Mantoux Date/Results:_____

Was this Child screened for high cholesterol? □ YES □ NO At Risk□ YES □ NO If Yes, Results:_____

Is this Child at risk for Anemia? □ YES □ NO
Hemoglobin Screening Date ___/___/___ Result:_____ Normal___ Abnormal___
Hematocrit Screening Date ___/___/___ Result:_____ Normal___ Abnormal___

Vision/Hearing- (Perform subjectively between 0-3 years - subjective) (Perform objectively at 3 years and 4 years-)
Vision Date:___/___/____ Result: R- ___/20 L- ___/20 Corrective lenses? □ YES □ NO
Hearing Date:___/___/____ Result: R- ___dB L- ___dB Hearing Aids? □ YES □ NO

Measurements

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. Is a special diet required?	☐ YES ☐ NO	
3. Does child have asthma/ RAD?	☐ YES ☐ NO	
4. Does child require any medications to be administered at school? (Specify order)	☐ YES ☐ NO	
5. Does this child have any hearing, visual, or dental conditions?	☐ YES ☐ NO	
6. Has this child/parent received anticipatory guidance according to recommendations of the NYS EPSDT in the areas of Violence Prevention; Injury Prevention; and Nutritional Counseling?	☐ YES ☐ NO	
7. 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	

Physical Exam

Area Assessed	Normal findings?	Comments/Description
Gait/Motor Ability	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Mouth/Throat	☐ Yes ☐ No	
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Head/Face/Neck	☐ Yes ☐ No	
Lymph Nodes	☐ Yes ☐ No	
Lungs/ Chest	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Abdomen/ Gastrointestinal	☐ Yes ☐ No	
GU	☐ Yes ☐ No	
Psychological	☐ Yes ☐ No	
Neurologic	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Back	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	
Gait/Motor Ability	☐ Yes ☐ No	
Speech	☐ Yes ☐ No	
Developmental	☐ Yes ☐ No	
Behavioral	☐ Yes ☐ No	

Does this child have any contagious or communicable disease? ☐ **YES** ☐ **NO**
On the basis of my findings, this child is able to participate in the Head Start/Day care ☐ **YES** ☐ **NO**
Is this child being referred to another physician or dentist? ☐ **YES** ☐ **NO**
Referred to?_____

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

_____
_____
_____
_____

_____ _____
Signature of Examiner **Date**

_____ _____
Please Print Name **Title**

_____ _____
Address **Phone**

Child's Name_____