Head Start/Early Head Start

Physical Form

To Be Completed & Signed By a Health Care Professional

Fax # 812-849-0627

Child's Name	Birth Date & Age at Exam	Gender

Exam Date	Height	Weight	Blood Pressure	Head Cir.

Assessment	Normal	Comments/Follow-up Needs	Assessment	Normal	Comments/Follow-up Needs
Eyes/Vision			Ears/Hearing		
Acuity: Right Left Strabismus: Yes/No			Test used: Results:		
Mouth/Dental			Communication		
Development			Mental Health		

☐ This child " Passed" this well child exam & has NO abnormal findings.

☐ This child "Failed" this well child exam due to the following findings: _____

_____

Critical Health Information: _____

(special needs/referrals/treatment) _____

This child is receiving treatment for the following conditions:

☐ Asthma ☐ Hearing Difficulties ☐ Obesity ☐ Speech Services

☐ Anemia ☐ Vision Problems ☐ Failure To Thrive ☐ Mental Health Services

☐ Diabetes ☐ High Lead Level ☐ Heart Condition

Describe treatment: _____

_____

Hemoglobin	Date	Results	Not Medically Needed	Lead	Date	Results	Not Medically Needed
9-12 months				9-12 months			
2 years				2 years			
5 years							

TB test	Date	Results	Not Medically Needed	Urinalysis	Date	Results	Not Medically Needed
12 mos./@ risk				5 years			

Immunizations: ***(Please attach record or waiver)***

☐ Complete for age ☐ Behind, but has had all possible at this time ☐ Past due

☐ This child has a waiver

Nutrition:

☐ This child has food allergies which include: _____

_____

☐ This child requires a special diet which includes: _____

_____

Physician/Health Care Provider Signature	Date