

**ATTENTION PROVIDER:**

*Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM. Documentation of ALL screenings are necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.*

Center: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)**

Periodicity visit for:    1-2    3-4    5-6    7-9    10-12    13-15    16-23    2    3    4    5  
                                  Mos    Mos    Mos    Mos    Mos    Mos    Mos    Yr   Yr   Yr   Yr

Examination Date: \_\_\_\_\_

Practice/Clinic Name: \_\_\_\_\_

Provider (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

<b>Height:</b> ( %)		<b>Weight:</b> ( %)		<b>Blood Pressure:</b>		<b>Head Circumference:</b>	
Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested
General Appearance				Eyes			
Posture, Gait				Ears			
Speech				Genitalia			
Head/Neck				Muscular Coordination			
Skin				Motor Ability			
Mouth/Teeth				Self-help/Social Skills			
Heart				Communication Skills			
Lungs				Cognitive Skills			
Abdomen (Hernia)				<b>Allergies (List):</b>			

**LABORATORY**

<b>Hematoerit/Hemoglobin</b>	Date:	Results:	<b>Immunizations Given This Visit:</b>				
<b>Lead</b>	Date:	Results:	<input type="checkbox"/> Polio	<input type="checkbox"/> DTP/DTaP	<input type="checkbox"/> MMR	<input type="checkbox"/> HepB	<input type="checkbox"/> HIB
<b>Sickle Cell</b>	Date:	Results:	<input type="checkbox"/> Other (List):				
<b>Urinalysis</b>	Date:	Results:	Next Shots Due/Date:				
<b>Tuberculin Skin Test</b>	Type:	Date of Test:	Date Read:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Rx Date:	Chest X-ray Date:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive

**VISION**

Date: \_\_\_\_\_

**HEARING**

Date: \_\_\_\_\_

Acuity - Right Eye:	/	Frequency	1000	2000	3000	4000
Acuity - Left Eye:	/	Right Ear	dB	dB	dB	dB
Strabismus:		Left Ear	dB	dB	dB	dB

**Findings, Treatments & Recommended Follow-up:**

**List Medications:**