ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD TESTS FOR LEAD and HEMOGLOBIN. Documentation of ALL screenings is 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.

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

CHILD'S NAME	DATE OF BIRTH	CENTER
		Pueblo of Isleta Head Start

WELL CHILD EXAM PERFORMED TODAY (PLEASE CHECK ONE)

☐ <1 mo ☐ 2 mos ☐ 4 mos ☐ 6 mos ☐ 9 mos ☐ 12 mos ☐ 15 mos ☐ 18 mos ☐ 24 mos ☐ 30 mos

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM

ADDRESS

EXAMINATION RESULTS

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE *(Required up to 24 months of age)*
inches	lbs/oz	centimeters

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth/Teeth/			Abdomen		
Head			Oral Health Assessment			Genitalia		
Neck			Throat			Neurologic		
Lymph Nodes			Chest			Extremities		
Eyes			Lungs			Motor Ability		
Ears			Heart			Psychological		
Nose			Back			Speech		

Sensory Screenings (Clinical Assessments)

VISION ASSESSMENT ☐ Normal ☐ Abnormal

HEARING ASSESSMENT ☐ Normal ☐ Abnormal

Immunizations

IMMUNIZATIONS GIVEN TODAY

☐ Hepatitis B ☐ DTaP ☐ PCV ☐ Rotavirus
☐ MMR ☐ Polio ☐ Hib
☐ Influenza ☐ Varicela ☐ Hepatitis A

Hemoglobin (Required at 12 months)

DATE	HGB(g/dl)	☐ No Risk Anemia

TREATMENT ☐ Anemia ☐ Iron Prescribed

DATE OF FOLLOW-UP APPOINTMENT

Lead

DATE	LEAD LEVEL @ 12 MOS. mcg/dL

DATE	LEAD LEVEL @ 24 MOS. mcg/dL

Medicaid requires a lead test at 12 and 24 months.

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS	☐ Non Significant	☐ Significant	DATE READ
	mm			

DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE

Lead Risk Assessment

☐ At Risk ☐ No Risk

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		
Dental Screening		

Diagnosis/Abnormal Findings

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL

☐ Yes ☐ No **(If yes, Medication Administration form needed)**

TYPE OF MEDICATION AND PURPOSE

Treatment/Restrictions/Recommendations for School

Child is physically and emotionally able to participate in program

☐ Yes ☐ No ***(If no, please explain in space above)***

Date Received Completed Physical Form:_____ **Staff Name:**_____

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is 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.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE 3 Yr ☐ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER
		Pueblo of Isleta Head Start

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM

ADDRESS

EXAMINATION RESULTS

HEIGHT	WEIGHT	BLOOD PRESSURE
inches	lbs/oz	

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth/Teeth/ Oral Health Assessment			Genitalia		
						Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Developmental		
Nose			Abdomen			Behavioral		

Vision Acuity		Right	Left	Both	Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date		/	/	/	Date		1000 Hz	dB	dB
							2000 Hz	dB	dB
Test Type					Test Type		3000 Hz	dB	dB
							4000 Hz	dB	dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	
		☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS			DATE READ
	mm	☐ Non Significant	☐ Significant	

DATE OF CHEST X-RAY			RX DATE
	☐ Normal	☐ Abnormal	

Lead Risk Assessment

☐ At Risk ☐ No Risk

Immunizations

GIVEN TODAY

☐ Yes ☐ No List:_____

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Treatment/Restrictions/Recommendations for School

Does the child have asthma?

☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL

☐ Yes ☐ No **(If yes, Medication Administration form needed)**

Child is physically and emotionally able to participate in program

☐ Yes ☐ No **(If no, please explain in space above)**

TYPE OF MEDICATION AND PURPOSE

Date Received Physical Completed Form:_____ **Staff Name:**_____