Head Start Physical

2016-2017

This form follows AAP recommendations for Well Care Visits and NYS Health Dept. EPSDT Guidelines.

Rec'd date___

Child's Name:	Date of Birth:	Parent/Guardian Name:

Date of Exam:	BP: ◻Nrml ◻Abnl	Height: ◻Nrml ◻Abnl	Weight: ◻Nrml ◻Abnl	Vision: ◻Nrml ◻Abnl R: L:	Hearing: ◻Nrml ◻Abnl R: L:

PHYSICIAN PLEASE NOTE: Federal Head Start Guidelines require information regarding this child's Hemoglobin, Lead Level and Blood Pressure, Hearing and Vision Screenings per NYS EPSDT.

If not done w/in one year, please indicate date and results from most recent test and indicate Current Risk.

Hemoglobin	Most recent date:	Result:	Current Risk? Yes or No
Lead	Most recent date:	Result:	Current Risk? Yes or No

PHYSICAL EXAM	ABNORMALITIES? YES	NO	DESCRIPTION
Head			
EENT			
Heart			
Lungs			
Abdomen			
Hernia			
Musculo-Skeletal			
Genitalia			
Skin			
Neurological			
Gait/Posture			
Important Health Problems	**YES**	**NO**	**DESCRIPTION**
Allergies (Please see reverse)			Type & Restrictions
Daily Medications			Type & Dosage
Nutritional Concerns			Describe any dietary accommodations
Developmental concerns			
Mental Health			
Disabilities			
Asthma			
Seizures			
Diabetes			

Describe any significant medical, surgical or illness history in past 2 years :

Child lives in a home with fluoridated water? Yes No If no, prescription has been issued to obtain fluoride? Yes No

Please attach child's immunization record to this form.

Are Immunizations up to date? Yes No If no, please list next appointment date:___

Recommendations for Treatment, Evaluations, Social and/or Educational Service:

Referrals made to:

Can this child have a regular diet at school, including milk? ◻ Yes ◻No ****If No, please see back of form.

On the basis of my findings, indicated above, and knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease and is able to fully participate in all Head Start and daycare indoor and outdoor activities ◻ Yes ◻No

Comments:___

Physician Name: ___

Address:___ Phone Number:___

Are you this child's primary care physician? ◻ Yes ◻No

Physician's signature___ Date of signature___

Please return this form to: Watervliet UPK 2557 10th Avenue Watervliet, NY 12189
Phone: 518.629-3263 Fax: 518.629-3250