INSTITUTE FOR HUMAN AND SOCIAL DEVELOPMENT
Head Start | Early Head Start | State Pre-School
155 Bovet Road Suite 300, San Mateo, CA 94402
Phone: (650) 578-3440 Fax: (866) 312-4161

For IHSD use only
Date Rc'vd:_____
Initial: _____
Site Code: _____

Early Head Start (Birth- 35 months) Physical Exam

Child's Name:	DOB: / /	□ Male □ Female

Dear Provider, please complete the following:

1. This exam is for age in **Months** (please check): □ 2 □ 4 □ 6 □ 9 □□ 12 □□ 15 □□ 18 □ 24 mos.
2. Early Head Start requires a COMPLETE CHDP equivalent health exam. Please complete items below and provide a copy to the child's parent/guardian or fax (866) 312-4161. If there are abnormal results or a referral made, please provide details in "Comments." Questions? Call Health Manager (650) 578-3421. Thank you.

Date of this exam: ___/___/___		Date of next exam: / /
Procedure	**Results (please check box)**	**Comments**
History and physical exam	□ No problems □ Problems suspected □ Referred to:	
Vision—clinical observation	□ No problems □ Problems suspected □ Referred to:	
Hearing— non audiometric	□ No problems □ Problems suspected □ Referred to:	
Hemoglobin or hematocrit (**REQUIRED** at 9-12 & 24 mos)	Date: ___/___/___ Results: Hgb_____Hct _____ □ Normal □ Anemia □ Meds given □ Retest on:	
Blood lead test (**REQUIRED** at 12 & 24 mos)	Date: ___/___/___ Results:_____ Date: / / Results:	
TB test or risk assessment (Test **REQUIRED** if risk factors present)	□ No risk factors □ Risk factors present AND TB test: Date given:__/__/__ Date read: __/__/__ Results: **If no risk factors, specify reason(s) under comments:**	
Growth Assessment	Head Cir: _____cm / Ht: _____ inches Wt: pounds	
Dental assessment	□ No problems □ Problems suspected □ Referred to:	
Nutritional assessment	□ No problems □ Problems suspected □ Referred to:	
Developmental/behavioral	□ No problems □ Problems suspected □ Referred to:	
Psychosocial assessment	□ No problems □ Problems suspected □ Referred to:	
Tobacco assessment	□ Exposure to smoke/counseling provided □ No exposure	
Anticipatory guidance	□ Provided	
Blood lead risk assessment	□ No risk factors □ Risk factors present	
Immunizations Given:	□ Asthma / □ Allergies (specify)	List current medications:

Provider's Name: (please print)	Today's date: / /	Phone:
Provider's Signature:	Practice/Clinic Name:	