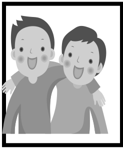

INSTITUTE FOR HUMAN AND SOCIAL DEVELOPMENT
Head Start | Early Head Start | State Pre-School
155 Bovet Road Suite 300, San Mateo, CA 94402
Phone: (650) 578-3440 Fax: (866) 312-4161

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

Head Start (3 -5 years) Physical Exam

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

Dear Provider, please complete the following:

1. Age of child when exam was done (please check): □ 3 year □ 4 year □ 5 year
2. 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 <u>this</u> exam: _____/_____/_____

Procedure	Results (please check box)		Comments
History and physical exam	□ No problems □ Problems suspected □ Referred to:		
Vision— visual acuity test	□ No problems □ Problems suspected □ Referred to: □ Unable to test		
Hearing— pure tone audiometric	□ No problems □ Problems suspected □ Referred to: □ Unable to test		
Hemoglobin or hematocrit (**REQUIRED** at 3, 4, 5 yrs)	Date: ___/___/___ Results: Hgb______ Hct _____ □ Normal □ Anemia □ Meds given □ Retest on:		
Blood lead test (**REQUIRED** now if not done at 2 yrs)	Date: ___/___/___ Results:_______		
TB test or risk assessment (Test **REQUIRED** at 4 yrs and any if age risk factor present)	□ No risk factors □ Risk factors present AND Test: Date given:___/___/___ Date read:___/___/___ Results: **If no risk factors, specify reason(s) under comments:**		
Height & weight	_______ inches _______ pounds □ Normal □ Overweight □ Underweight		
Blood pressure	Results:		
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		
Immunizations Given:	□ Asthma	□ Allergies (specify)	List current medications:

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