This form can be faxed directly to Head Start at 801-781-3443
Thank you!

For HS Staff Use Only:

Date of parent permission form (HSAP1): _____

Head Start/Early Head Start Physical Examination Form

Child's Name: _____ Date **of Birth**: _____

Parent/Guardian's Name: _____ **Site/Class**: _____

Insurance provider: _____ **Family Service Worker:** _____

Physician's Name:_____**Physician's Phone**: _____

*** Head Start Standards require that all Head Start children receive a blood pressure check, a HGB or HCT, and a lead test, in addition to an EPSDT / CHEC physical. Please include all numeric values for necessary screenings.**

Exam Date: _____

Blood Pressure value: ____/____
Pass_____ Fail_____

Blood Lead Level Test value:_____
Pass_____ Fail_____

Hemoglobin or Hematocrit value:_____
Pass_____ Fail_____

Length/Height_____ **Weight**_____ Pass_____Fail_____

Head Circumference: (if 24 months or younger): _____

Are there concerns about this child's growth? YES____ NO____

Vision Screening: Value: _____ Pass_____ Fail_____

Hearing Screening: Pass_____ Fail_____

Autism Screening: Pass_____ Fail_____

Evaluation	Normal	Abnormal Findings	Evaluation	Normal	Abnormal Findings	Does the child have any of the conditions below?	
General Appearance			Genito-urinary				Yes
Posture			Bones, Joints			Asthma	
Skin			Gross Motor			Diabetes	
Head, Hair			Fine Motor			Allergies	
Eyes: PERRL, EOM			Muscles			Seizures	
Ears: cerumen			Lymph Nodes			Cerebral Palsy	
Nose			Abdomen			Cancer	
Mouth, teeth, pharynx			Reflexes			Spina-Bifida	
Neck, thyroid			Neurological			Disabilities	
Heart & Circulatory			Spinal Alignment			Tube feeding	
Chest & Lungs			Social Development			Malnutrition	

Normal Well-Child Exam _____ **OR** ***Concerns were Identified (Please list below):***

Comments: Please list any additional health concerns (and on-going treatments). _____

_____

Abnormal Findings or Concerns	Treatment Plan	Recommended Follow-up

Physician's Signature: _____ **Date:** _____

Thank you!