



EARLY HEAD START PHYSICAL EXAM FORM

2002 Sudderth Dr. Ruidoso, NM 88345
 Phone: (575) 651-1802 Fax: (575) 855-625-5183

Early Head Start requires a COMPLETE HEALTH EXAM, including BLOOD TESTS FOR LEAD and HEMATOCRIT. 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 or fax to the number above.

CHILD'S NAME			DATE OF BIRTH		
Well child check performed today (Please check one) <input type="checkbox"/> <1mo <input type="checkbox"/> 2mos <input type="checkbox"/> 4mos <input type="checkbox"/> 6mos <input type="checkbox"/> 9mos <input type="checkbox"/> 12mos <input type="checkbox"/> 18mos <input type="checkbox"/> 24mos <input type="checkbox"/> 30mos					
HEALTH CARE PROVIDER INFORMATION					
PHYSICIAN NAME			SIGNATURE (Required)		
CLINIC/TYPE OF PRACTICE		TELEPHONE		DATE OF EXAM	
ADDRESS					
EXAMINATION RESULTS					
Height: _____ inches		Weight: _____ lbs. _____ oz.		BP: ____ / ____	BMI _____%
Head Circumference: _____ inches					
EXAM	<i>Results:</i>	EXAM	<i>Results:</i>	Sensory Screening	
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Genitalia	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	VISION ASSESSMENT	
EENT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Neurologic	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Right / Left /	
Lymph Nodes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Motor Ability	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Heart	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Emotional	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	HEARING ASSESSMENT	
Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Social	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Musculoskeletal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Speech	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Behavioral	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Anemia Testing (12 mos.)		Lead (12 and 24 mos)		Immunizations	
DATE: _____ HEMOGLOBIN _____(g/dL) OR DATE: _____ HEMATOCRIT _____%		DATE: _____ LEAD LEVEL @ 12 mos. (mcg/dl): _____ <input type="checkbox"/> No risk <input type="checkbox"/> Refer		<input type="checkbox"/> Up to Date <input type="checkbox"/> Deferred/Exempt Immunizations Given Today (if applicable):	
<input type="checkbox"/> No Risk <input type="checkbox"/> Refer		DATE: _____ LEAD LEVEL @ 24 mos. (mcg/dl): _____ <input type="checkbox"/> No risk <input type="checkbox"/> Refer		<input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> PCV <input type="checkbox"/> Rotavirus <input type="checkbox"/> MMR <input type="checkbox"/> Polio <input type="checkbox"/> Hib <input type="checkbox"/> Varicela <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Influenza <input type="checkbox"/> COVID	
Chronic Disease Assessment					
Does the child have allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list)				Epipen required? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Is medication required at school? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Authorization to Administer Medication form will need to be completed by provider)					
Does this child need treatment or have recommendations for school? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain)					

For Program Use Only:	
Date Received:	Received By:

