



HEAD START PHYSICAL EXAMINATION



Child's Name:	Birthday:	Age:
Head Start Center:		RM:

Test	√ Normal for Age	√ Abnormal	If Abnormal Note Comments, Treatment or Recommendations (use additional sheet if necessary)
1) Height			
2) Weight			
3) Blood Pressure			
4) Head Circumference (0-24 months only)			
5) Indication of Iron Deficiency Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:			Date: _____ Hematocrit _____ % or Hemoglobin _____ (Mandatory blood test if not received at age 2 or anytime after. Document date & result if received at age 2 or anytime after.)
6) Concern with Lead <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:			Date: _____ Blood Lead Screening Result _____ (Mandatory blood test if not received at age 2 or anytime after. Document date & result if received at age 2 or anytime after.)
7) Concern with TB <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:			
8) Hearing			
9) Vision			
10) Posture, Gait			
11) Speech			
12) Head			
13) Skin			
14) Eyes A) External Aspects B) Optic Fundiscopic C) Cover Test			
15) Ears A) External & Canals B) Tympanic Membranes			
16) Nose, Mouth, Pharynx			
17) Teeth			
18) Heart			
19) Lungs			
20) Abdomen (include hernia)			
21) Genitalia			
22) Bones, Joints, Muscles			
23) Neurological/Social A) Gross Motor _____ B) Fine Motor _____ C) Communication Skills _____ D) Cognitive _____ E) Self-Help Skills _____ F) Social Skills _____			
24) Glands (Lymphatic/Thyroid)			
25) Muscular Coordination			
26) General Appearance			
27) Child's General Physical Status			

Clinic:	Physician Signature:	Date Physical Complete: