Area Five Agency Head Start
PHYSICAL EXAM FORM
1801 Smith Street
Logansport, IN 46947
Phone (574)722-4451 Fax (574)722-3447

Child's Name: _____ Birth Date: _____ Source of Payment: _____

HEALTH CARE PROVIDER: Head Start requires a full Medicaid/EPSDT exam for all Head Start children. Please complete the following:

REQUIRED SCREENINGS/TESTS Note: Labs need to be dated at 2 years of age or later.

Please write numerical results.	If result outside of NL, please indicate plan of care.
Height: Weight: BMI:	WNL: Yes No
Blood Pressure:	WNL: Yes No
Hearing Left: Right:	WNL: Yes No
Vision Left: Right:	WNL: Yes No
Hemoglobin Date: **Result:**	WNL: Yes No
Lead Date: **Result:**	WNL: Yes No

Unclothed Physical Exam: Note any unusual findings.

Skin:	Heart:
Lymph nodes:	Lungs:
Eyes:	Abdomen:
Nasopharynx:	Genitalia:
Teeth & Mouth:	Skeleton:
Ears:	Other:

Significant Health/Developmental History:_____

_____

_____

_____

ALLERGIES

_____

_____

If food allergy, please specify substitute:

_____

_____

*Note: for lactose intolerance, lactose-free milk is the substitute recommended by the USDA Child Care Food program.

TB Risk Assessment

Is an intradermal tuberculin (Mantoux) skin test indicated?

____ Yes ____ No

If indicated, please administer and record result below.

Date placed: _____

Date read: _____ Result: _____

Immunizations

Please attach a current immunization record, including any immunizations given today. Head Start requires children to be immunized according to the Center for Disease Control and Prevention schedule. This differs from ISDH school requirements.

Are immunizations up-to-date according to CDC schedule?

_____ Yes _____ No

Does this child have any health conditions that would be hazardous to him/herself or to other children in a group setting as a result of participation in normal activities? Yes No _____

Have you prescribed any medications or special routines that should be followed at Head Start preschool?

Yes No _____

_____

SUMMARY: ALL PLANNED TREATMENT ___ IS ___ IS NOT COMPLETE. If not complete, describe: _____

_____ _____ _____

Physician's Signature Date of Exam Physician's Printed Name and Office Number (or stamp)

AFTER COMPLETION, YOU MAY FAX THIS FORM DIRECTLY TO HEAD START AT: (574)722-3447.