



GEMINUS HEAD START
PHYSICAL EXAMINATION

Date of Exam: _____

Child's Name: _____ Birth date: ____/____/____ Sex: _____ Age: _____

Height: _____ Weight: _____ BMI: _____

B/P: (EPSDT requirement for children 3 or over) _____

Head Circumference (0 – 24 months only) _____

*Lead Level: Date ____/____/____ Result _____ *Hemoglobin: Date ____/____/____ Result _____

***Head Start requires proof of 9 month and 24 month old lead and hemoglobin screenings or child must be screened**

Add'l work (to be done at physician's discretion) Sick Cell: Date _____ Result _____ TB Test: Date _____ Result _____

EXAMINATION	NORMAL	ABNORMAL	COMMENTS	Is the child receiving treatment for any of the following conditions?		
				Condition	Yes	No
Head				Anemia		
Eyes				High Lead Levels		
Nose				Overweight		
Throat				Underweight		
Chest				Does Child Wear Glasses		
Mouth/Dental				If 'Yes' to any above questions, what is treatment plan?		
Cardiovascular/HTN						
Respiratory						
Endocrine						
Genito-Urinary						
Neurological						
Musculoskeletal						
Spinal Exam						
Nutritional status						
Sleep Habits						
Self Help Skills						
Mental Health						
Speech						
Motor						
Cognitive						
Social						
<i>If 'Yes' to the following questions, please provide Comments</i>						
Has child ever been hospitalized or operated on?			_____ Yes _____ No			
Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			_____ Yes _____ No			
Has child ever had a serious illness?			_____ Yes _____ No			
Is child currently being treated by a physician?			_____ Yes _____ No			
Is child taking medications at this time?			_____ Yes _____ No			
Does child have any physical limitations that prevent full participation, including outdoor activity?			_____ Yes _____ No			

GEMINUS HEAD START/EARLY HEAD START
PHYSICAL EXAMINATION

QUESTIONS	Yes	No
Does child have:		
Asthma <i>(If yes, please complete and attach Follow-up Care Plan)</i>		
Allergies <i>(If yes, please complete and attach a Follow-up Care Plan)</i>		
Diabetes <i>(If yes, please complete and attach a Follow-up Care Plan)</i>		
Seizures <i>(If yes, please complete and attach a Follow-up Care Plan)</i>		
Bee sting allergy <i>(If yes, please complete and attach a Follow-up Care Plan)</i>		
Other _____ <i>(If yes, please complete and attach a Follow-up Care Plan)</i>		

Immunization record

	(1)	(2)	(3)	(4)	(5)
DTAP	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
HepB	_____	_____	_____	_____	_____
PCV	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
Other	_____				

*Hep B #4 required if #3 was given before 24 weeks.

Please Print or Stamp

Physician's Name: _____

Address: _____

Phone: _____

Fax: _____

Physician's Signature Date