



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