Chugachmiut Head Start
Physical Form

Child's Name:				Date of exam:
Child's Age:	Child's DOB:	Parent or Guardian's name:		
Height:	Weight:	BMI:	Blood Pressure:	Is blood pressure WNL? Y or N

RISK FACTORS REVIEWED:		**NORMAL**	**ABNORMAL**	**REFER**	**NOT EXAMINED**	**NOTES: ANY REFERRAL NEEDS? (IF YES DESCRIBE)**
1.	General Appearance					
2.	Posture, Gait					
3.	Skin					
4.	Vision Screen Strabismus? Y or N					Left: 20/____ Right:20/_____ Both: 20/_____
5.	Ears (external aspect)					
	Hearing Screen					Left: Pass_____ Not Pass:_____ Right: Pass_____ Not Pass:______
6.	Nose, Mouth, Pharynx					
7.	Teeth/Gums					
8.	Heart					
9.	Lungs					
10.	Abdomen					
11.	Bones, joints, muscles					
12.	Gross motor					
13.	Fine motor					
14.	Glands (Lymphatic/Thyroid					
15.	Muscular Coordination					
16.	Nutrition Assessment					

DISEASE PREVENTION AND RECOMMENDATIONS: EPSTD REQUIRES TB & LEAD RISK ASSESSMENTS EVERY YEAR FROM 3-6 YEARS	
1.	Is child up-to-date on a schedule of age appropriate preventative and primary health care? ☐ Yes ☐ No **(provide current immunization record)** **NOTES:**
2.	Does child need to establish or be referred for any of the following services? ☐ Dental Care ☐ Hearing Screening ☐ Mental Health ☐ Evaluation by Registered Dietician ☐ Speech and Language ☐ Other:
3.	List any acute or chronic conditions, including allergies, or asthma, if any:
4.	Any current medications?
5.	Child's Status was determined by: ☐ Parent report ☐ Medical history ☐ Today's exam **Recommended Follow Up:**

MANDATORY HEAD START TESTS: HEMOGLOBIN , TB SCREEN AND PROOF OF LEAD SCREENING UPON ENROLLMENT		
Hemoglobin (results): **or** Hematocrit (results): ☐ Pass (11.1 HgB or above) ☐ Fail	Lead Screening : ☐ Pass ☐ Fail Copy of Lead Questionnaire: ☐	Parent Declined Screen Y or N Date:_____________
Date of TB Screening:	Copy of TB Questionnaire Attached: ☐	

PROVIDER INFORMATION		
PROVIDER NAME:	Provider Signature:	Date: