Early Childhood Education Services
Early Childhood Education Programs

Physical Examination

Child's Name: _____ Date of Physical Examination: _____

Date of Birth: _____

Head Start requires a complete CHDP equivalent health examination for entrance into the program.

CHDP Periodicity visit for:	1-2 Mos	3-4 Mos	5-6 Mos	7-9 Mos	10-12 Mos	13-15 Mos	16-23 Mos	2 Yrs	3 Yrs	4 Yrs	5 Yrs

TB Risk Factor Assessment	Blood Lead Risk Factor Assessment	Tobacco Assessment
❑ Risk factors not present; TB skin test not required	❑ Risk factors not present ❑ Risk factors present	❑ Yes ❑ No

Hematocrit /Hemoglobin 9 Month 2,3,4 Years	Date:	Results:	Anemia: ❑ Yes ❑ No	Iron Supplements: ❑ Yes ❑ No	
Blood Lead Test: 12 and 24 Month If no record, perform	Date:	Results:	Blood Pressure:	Date:	Results: ____ / ____
Tuberculin Skin Test	Date Given:	Date Read:	Results: ☐ Negative ☐ Positive	Chest X-ray Date:	Results: ☐ Negative ☐ Positive

Height: (%)	Weight: (%)	BMI:	Head Circumference:
Vision: Right – 20/_____	Left – 20/ _____	Strabismus: ❑ Pass ❑ Fail	Hearing: ❑ Pass ❑ Fail

Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested
General Appearance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Muscular Coordination, Motor Ability			
Ears/Nose/Throat				Anticipatory Guidance			
Seizures				Social-Emotional			
Mouth/Teeth Dental/Nutrition				Self-help/Social Skills			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (Hernia)				Behavior			

Is the child cleared to enter preschool? ❑ Yes ❑ No

List any allergies, chronic conditions or special accommodations: _____

_____

List medications required at school (include medication name and dosage): _____

_____

Provider (Please print): _____ Signature: _____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____