Health Examination
Head Start

Eligible Applicant_____ _____ _____ **Date of Birth**____/_____/_____
First Name **MI** **Last Name**

Date of Exam_____/_____/_____ **Provider Setting:** **Hosp/Clinic/Med Office**_____ **School** _____ **Other**_____

General Appearance	☐Normal	☐Abnormal	☐Referral	**Blood Pressure** **Systolic** _____ **Diastolic**_____
Posture, Gait	☐Normal	☐Abnormal	☐Referral	**Hematocrit/Hemoglobin** **Test Results** _____
Speech	☐Normal	☐Abnormal	☐Referral	**Hearing** **Pass**_____ **Fail**_____ **Re-screen**_____ **Referral**_____
Head	☐Normal	☐Abnormal	☐Referral	**Vision**
Skin	☐Normal	☐Abnormal	☐Referral	**Right Eye 20/**_____ **Pass**_____ **Re-screen**_____ **Referral**_____ **Left Eye 20/** _____ **Pass**_____ **Re-screen**_____ **Referral**_____ **Both Eyes 20/** _____ **Pass**_____ **Re-screen**_____ **Referral**_____
Eyes External Aspects	☐Normal	☐Abnormal	☐Referral	**Lead Screening** **Test Results**_____ **Pass**____ **Fail**____ **Re-screen**____ **Referral**____
Optic Fundoscope	☐Normal	☐Abnormal	☐Referral	**Mental Health Assessment**
Cover Test	☐Normal	☐Abnormal	☐Referral	**Normal** _____**Abnormal** _____**Further Evaluation**_____
Ears Internal Aspects	☐Normal	☐Abnormal	☐Referral	**Comments:**
Ears External Aspects	☐Normal	☐Abnormal	☐Referral	**Health Care Professional has determined that the child: Is up to date on all immunizations appropriate for their age: Yes____ No____** **Has received all possible immunizations at this time, but not appropriate for their age: Yes____ No _____** **The child is on a catch up schedule and will receive the next dose of** **_____DATE_____** **_____DATE_____** **_____DATE_____** **_____DATE_____** **_____DATE_____** **_____DATE_____**
Nose, Mouth Pharynx	☐Normal	☐Abnormal	☐Referral	
Teeth	☐Normal	☐Abnormal ☐Cavities	☐Referral	
Heart	☐Normal	☐Abnormal	☐Referral	
Lungs	☐Normal	☐Abnormal	☐Referral	
Abdomen (Include Hernia)	☐Normal	☐Abnormal	☐Referral	
Genetalia	☐Normal	☐Abnormal	☐Referral	
Bones, Joints, Muscles	☐Normal	☐Abnormal	☐Referral	
Neurological /Social	☐Normal	☐Abnormal	☐Referral	**Any additional information on child's immunization status:** _____ _____ _____ _____ _____ _____ _____
Gross Motor	☐Normal	☐Abnormal	☐Referral	
Fine Motor	☐Normal	☐Abnormal	☐Referral	
Communication Skills	☐Normal	☐Abnormal	☐Referral	
Cognitive	☐Normal	☐Abnormal	☐Referral	
Self-Help Skills	☐Normal	☐Abnormal	☐Referral	**Anticipatory Guidance:**
Social Skills	☐Normal	☐Abnormal	☐Referral	
GlandsLymphatacy/Thyroid	☐Normal	☐Abnormal	☐Referral	
Muscular Coordination	☐Normal	☐Abnormal	☐Referral	

General Statement on Child's Physical Status:

_____ _____ _____
Health Care Professional Signature **Date Completed** **Agency Name**

HEAD START OFFICE USE ONLY: Date Acquired: _____ Staff Initials: ____