GEMINUS HEAD START/EARLY HEAD START
PHYSICAL EXAMINATION

Date of Exam: _____

Child's Name: _____ Birth date _____/_____/_____ Sex : _____ Age: _____ ☐ **Head Start** ☐ **Early Head Start**

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*) Sickle Cell : Date _____ Result _____ TB Test: Date _____ Result_____

EXAMINATION	NORMAL	ABNORMAL	COMMENTS
Head			
Eyes			
Nose			
Throat			
Chest			
Mouth/Dental			
Cardiovascular/HTN			
Respiratory			
Endocrine			
Genito-Urinary			
Neurological			
Musculoskeletal			
Spinal Exam			
Nutritional status			
Sleep Habits			
Self Help Skills			
Mental Health			
Speech			
Motor			
Cognitive			
Social			

Is the child receiving treatment for any of the following conditions?		
Condition	**Yes**	**No**
Anemia		
High Lead Levels		
Overweight		
Underweight		
Does Child Wear Glasses		

If 'Yes' to any above questions, what is treatment plan?

If 'Yes' to the following questions, please provide Comments

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 illiness? _____**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**	

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

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