Volunteers of America GREATER LOS ANGELES

Head Start

Physical Exam Form

LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	SEX ☐ M ☐ F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN
AGENCY NAME	SITE NAME		

TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)		SIGNATURE
CLINIC TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

HEIGHT	WEIGHT	HEAD
inches (%)	lbs/oz (%) BMI for age (%)	CIRCUMFERENCE

Anticipatory Guidance Provided ☐ Yes ☐ No Fluoride Varnish Applied ☐ Yes ☐ No

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Blood Pressure (3+)			Mouth/Teeth/			Genitalia		
Skin			Oral Health Assessment			Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Hearing Assessment		
Nose			Abdomen			Vision Assessment		

Vision Acuity (Age 3+)		Right	Left	Both
Date		/	/	/
Test Type				

Hearing Screening (Age 4+)		Frequency (Hz)	Right (db)	Left (db)
Date		1000 Hz	dB	dB
Test Type		2000 Hz	dB	dB
		3000 Hz	dB	dB
		4000 Hz	dB	dB

Hemoglobin			Lead		
DATE	**HGB(g/dl)**	☐ No Risk Anemia	DATE	**Lead Level (mcg/dl)**	☐ No Risk
TREATMENT		DATE OF FOLLOW-UP	Medicaid requires at least one lead level between 24 & 72 months		

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	Non Significant ☐	Significant ☐	DATE READ

DATE OF CHEST X-RAY	Normal ☐	Abnormal ☐	RX DATE

Dyslipidemia Screening

SCREENING ☐ Risk Factors Present ☐ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No

DATE (OR AGE) NEXT PHYSICAL EXAM DUE

Diagnoses/Abnormal Findings	Treatment/Restrictions/Recommendations for School

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No (If yes; Physician Authorization Forms Needed)

TYPE OF MEDICATION AND PURPOSE

** RISK FACTORS FOR TB IN CHILDREN

- Have a family member or contacts with a history of confirmed or suspected TB
- Are in foreign-born families and from high-prevalence countries
- (Asia, Africa, Central and South America)
- Live in out-of-home placements
- Have, or are suspected to have, HIV infection
- Live with an adult with HIV seropositivity
- Live with an adult who has been incarcerated in the last five years
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes
- Have abnormalities on chest X-ray suggestive of TB
- Have clinical evidence of TB

Consult with your local health department's TB control program on any aspects of TB prevention and treatment

**California Community Care Licensing Form LIC701

TO BE COMPLETED BY HEAD START STAFF

NAME OF STAFF COMPLETING 1ST REVIEW	SIGNATURE	POSITION	DATE
NAME OF STAFF COMPLETING 2ND REVIEW	SIGNATURE	POSITION	DATE

Referred for Follow-Up to:

HEALTH	MENAL HEALTH	DISABILITIES	FAMILY SERVICES	EDUCATION	OTHER

Head Start Follow-Up & Notes

RECEIVED BY (PRINT NAME)	DATE RECEIVED