CAPE Head Start/ Early Head Start

401 SE 6th Street, Suite 001, Evanville, IN 47713
Main office: 812-425-4241 xt. 3987
Fax document to: _____

Physical Exam Form

CHILD'S NAME:_____BIRTHDATE:_____ AGE:_____ GENDER: ❑M ❑F

PARENT'S NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

Date of exam: _____ **Head Start Center/ Classroom #:** _____

*Required by Head Start

SCREENING TESTS		
TEST	RESULTS	COMMENTS
Height*		
Weight*		
Head Circumference*		
Blood Pressure		
Body Mass Index*		
Vision*		
Hearing*		
Blood Lead Screen*		12 & 24 mo. -or- once after 36 mo.

IMMUNIZATIONS

Please attach with this paperwork

Condition

Allergies:

Handicapping Conditions:

Other:

PHYSICAL EXAMINATION/ASSESSMENT			
NAME	NORMAL	ABNORMAL	COMMENTS
GENERAL APPEARANCE			
SPEECH			
SKIN			
HEART			
LUNGS			
BONES,JOINTS,MUSCLES			
NEUROLOGICAL			
(1) GROSS MOTOR			
(2) FINE MOTOR			
(3) COMMUNICATION SKILLS			
(4) COGNITIVE SKILLS			
(5) SELF HELP SKILLS			
(6) SOCIAL SKILLS			
GLANDS (Lymphatic/Thyroid)			
MUSCULAR COORDINATION			
STATE OF NUTRITION			
OTHER			

MEDICATIONS PRESCRIBED

Visual Acuity

R: _____ / _____ **L:** _____ / _____

Pass: _____ Refer: _____

DOES CHILD HAVE ASTHMA? ❑Yes ❑No IF YES, ACTION ASTHMA PLAN MUST BE COMPLETED

DOES CHILD HAVE AN ALLERGY? ❑Yes ❑No IF YES, ACTION ALLERGY/ANAPHYLAXIS EMERGENCY PLAN MUST BE COMPLETED

Are there any special modifications needed for this child? ❑Yes ❑No

If yes, explain:

Will preschool participation be injurious or harmful to this child or others? ❑Yes ❑No

Additional Comments:

_____

HEALTH PROVIDER AND ADDRESS

Provider's Name: _____

_____

Address: _____

_____

Telephone: _____

Signature of physician/nurse practitioner/physician assistant: _____ **Date:** _____