

PO Box 1117 1602 W. Ferguson Rd Mt. Pleasant TX 75455 (903)575-2092 fax (903)575-2077



Physical Exam

, ·	\square EHS (0-36 months) \square Head Start (3-5 years) \square Pre-K (3-5 years)				
Doctor/ Health Care Provider: The Head Start Program requires that each child have a complete health exam. Please complete ALL areas, sign, and date this form. Thank you Section 1 Physical Exam/Assessment Normal Abnormal Section 2-Standard Tests & Measurements					
Section 1 Physical Exam/Assessment	Child's name/Nombre del Niño	Birth	dav/Fecha de Nacimiento	Room/Salón	
Section 1 Physical Exam/Assessment	Doctor/ Health Care Provider: The Head Start Program requires that each child have a complete health exam.				
Normal Abnormal Blood Pressure	Please complete ALL areas, sign, and date this form. Thank you				
Skin	Section 1 Physical Exam/Assessment		Section 2-Standard Tests & Measurements		
Hgb & Lead are required at 12 months and Lead at 24 months or upon entering Head Start. Heart Lungs Abdomen Neuromuscular/Social Genitalia Comments: Please indicate any significant past medical history (surgeries, injuries, PT, OT, etc) Please indicate if there are any concerns regarding mental health or cognitive delays. By the child currently being treated for any medical conditions? Please state diagnosis and medication. Phone Number ()	Normal	Abnormal	Blood Pressure	/ HR	
Lead at 24 months or upon entering Head Start. Heart	Skin				
Lungs Abdomen Neuromuscular/Social Genitalia Comments: Please indicate any significant past medical history (surgeries, injuries, PT, OT, etc) Please indicate if there are any concerns regarding mental health or cognitive delays. By the child currently being treated for any medical conditions? Please state diagnosis and medication. Phone Number ()	EENT				
Abdomen	Heart				
Abdomen	Lungs		Lead Level	Date	
Genitalia Comments: Please indicate any significant past medical history (surgeries, injuries, PT, OT, etc) Please indicate if there are any concerns regarding mental health or cognitive delays. Doctor's Name (<i>Please Print</i>) Is the child currently being treated for any medical conditions? Please state diagnosis and medication. City, TX Zip Code	Abdomen				
Allergies: Please indicate any significant past medical history (surgeries, injuries, PT, OT, etc) Please indicate if there are any concerns regarding mental health or cognitive delays. Doctor's Name (Please Print) Is the child currently being treated for any medical conditions? Please state diagnosis and medication. City, TX Zip Code Phone Number ()	Neuromuscular/Social		1 1		
Please indicate any significant past medical history (surgeries, injuries, PT, OT, etc)	Genitalia				
history (surgeries, injuries, PT, OT, etc) Please indicate if there are any concerns regarding mental health or cognitive delays. Is the child currently being treated for any medical conditions? Please state diagnosis and medication. City,TX Zip Code Phone Number ()	Comments:				
Doctor's Name (<i>Please Print</i>) Address/Clinic City,TX Zip Code Phone Number ()				·	
Doctor's Name (<i>Please Print</i>) Is the child currently being treated for any medical conditions? Please state diagnosis and medication. City, TX Zip Code			Please indicate if there are	any concerns	
Address/Clinic City,TX Zip Code Phone Number ()			regarding mental health or	cognitive delays.	
Address/Clinic City,TX Zip Code Phone Number ()	Doctor's Name (<i>Please Print</i>)		Is the child currently be	ing treated for any	
Phone Number ()				.	
Phone Number ()	Address/Clinic		medication.		
Phone Number ()	City TV 7:5 Cod				
	,1X Zip Cod	e			
	Phone Number				
I certify that I have examined the above child on this date and that he/she is able to participate in Early Head Start/Head Start/Pre-K activities.	()				
t correspondent in the continuence of the control of this wate and that he side to participate in Early Head Start/Head Start/The Nactivities.	Leartify that I have examined the above child on this	late and that he/she is able to	harticipate in Early Head Start/Head Sta	urt/Pre-K activities	
Doctor/Health Care Provider Signature:EXAM Date:					