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

Physical Exam

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.*

Child's Name/*Nombre del Niño*

Birthday/*Fecha de Nacimiento*

FOR CDC USE ONLY:
Program:
☐ EHS (0-36 months)
☐ Head Start (3-5 years)
☐ Pre-K (3-5 years)
Classroom #:

Section 1 Physical Exam/Assessment

	Normal	Abnormal
Skin	☐	☐
EENT	☐	☐
Heart	☐	☐
Lungs	☐	☐
Abdomen	☐	☐
Neuromuscular/Social	☐	☐
Genitalia	☐	☐

Comments:
_____
_____
_____
_____
_____

Doctor's Name (***Please Print***)

Address/Clinic

_____
City _____,TX Zip Code_____

Phone Number
( )

Section 2-Standard Tests & Measurements

Blood Pressure_____/_____ HR ____
Height/Length_____ Weight_____HC____

Hgb & Lead *are required at 12 months and* ***Lead*** *at 24 months or upon entering* ***Head Start***.
HGB or HCT_____ Date _____
Lead Level _____ Date _____

Vision/Hearing: Subjective for **EHS** children
Vision: Pass Fail Hearing: Pass Fail

Child is up-to-date on a schedule of age appropriate preventive and primary health care: Yes ☐ NO ☐

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.
_____
_____
Is the child currently being treated for any medical conditions? Please state diagnosis and medication.
_____
_____
_____
_____
_____

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.

Doctor/Health Care Provider Signature: _____EXAM Date: _____