

Aleutian Pribilof Island Association, Inc. Head Start Physical Form

Child's Name:			Date of exam:		
Child's Age:		Child's DOB:		Parent or Guardian's name:	
Height:	Weight:	BMI:	Blood Pressure:	Head Circumference: Applicable only for 0-12 Months of Age	

RISK FACTORS REVIEWED:		NOT				NOTES
		NORMAL	ABNORMAL	REFER	EXAMINED	
1.	General Appearance					
2.	Posture, Gait					
3.	Skin					
4.	Vision					
5.	Ears (external aspect)					
6.	Nose, Mouth, Pharynx					
7.	Teeth/Gums					
8.	Heart					
9.	Lungs					
10.	Abdomen					
11.	Bones, joints, muscles					
12.	Gross motor					
13.	Fine motor					
14.	Glands (Lymphatic/Thyroid)					
15.	Muscular Coordination					
16.	Height					
17.	Weight					
18.	BMI					

DISEASE PREVENTION AND RECOMMENDATIONS	
1.	Is child up-to-date on a schedule of age appropriate preventative and primary health care? <input type="checkbox"/> Yes <input type="checkbox"/> No NOTES:
2.	Does child need to establish any of the following services? <input type="checkbox"/> Routine Dental Care <input type="checkbox"/> Routine Hearing Screening <input type="checkbox"/> Mental Health <input type="checkbox"/> Evaluation by Registered Dietician <input type="checkbox"/> Speech and Language <input type="checkbox"/> Other:
3.	List any acute or chronic conditions, including allergies, if any:
4.	Child's Status was determined by: <input type="checkbox"/> Parent report <input type="checkbox"/> Medical history <input type="checkbox"/> Today's exam

MANDATORY HEAD START TESTS	
Hemoglobin (results): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Finger-prick <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	or Hematocrit (results): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
TB Skin Test	Lead Screening (results): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date administered:	Read date:

PROVIDER INFORMATION		
PROVDER NAME:	Provider Signature:	Date: