

U.C.C.A.C., INC. - HEAD START

Dear Medical Health Care Provider:

Your patient has been accepted into the Head Start Program. As you know, NY State requires that all children be completely immunized and have a complete physical before they enter school. Head Start **requires** a complete Health assessment including: **Height, Weight, Blood Pressure, Vision and Hearing.**

The following routine blood tests are also requested:

Lead -NYS Law requires tests at age 1 and age 2,(repeat venous blood test is required for Lead results of 10 or greater).

HCT/HGB - following the American Academy of Pediatrics guidelines at age 9 months, age 2 years, 3 years, and 4 years.

Please record the most recent test results for these tests on the physical form.

In order to join us in class every child **must** have all of the required screenings listed above. Thank you for your cooperation. If you have any questions, please feel free to contact me at 338-8750 x112.

Holly S. Williams, LPN
Health Services Specialist

Child's Name _____ **Date of Birth** _____
Parent/Guardian _____ **Home Phone #** _____
Address _____

IMMUNIZATION RECORD (Month, Day, Year for each dose)

Immunization	Date					Immunization	Date
	1ST	2ND	3RD	4TH	5TH		
DTaP						MMR (1st)	
Polio (IPV)						MMR (2nd)	
HIB						Varicella	
Hepatitis B						Other(specify)	
Pneumococcal Conjugate							

The next appointment for immunization is scheduled for: (Month/day/Year) _____

Are there medical contraindications to immunization for this child? ()Yes ()No

If yes, specify the vaccine(s) and indicate the contraindications specified in the vaccine manufacturers package insert that apply to this child:

(Please Complete Other Side of Form)

GENERAL HEALTH RECORD

Name: _____

DATE OF EXAM: _____

The following information is **required** and must be entered by the Doctor's office:

Height: _____ Weight: _____ BMI _____ Blood Pressure: _____

Vision Screening: Acuity Results (example: 20/20)

R _____ / _____ L _____ / _____

Auditory Screening R _____ / _____ L _____ / _____

(Please result in decibels heard at frequencies 1000/2000/4000)

TEST RESULTS:

HGB/HCT: _____ Date: _____

LEAD: _____ Date: _____

(P- method >10 must be confirmed with a venous test) Please attach report of Lead screening

Are there any abnormalities of the following systems?
Describe fully, use additional sheet, if needed.

Tuberculin Test(Mantoux) Date: _____

Date Read: _____

Result: Positive: _____ Negative: _____

If positive attach Physician's statement documenting treatment and follow-up.

If Tuberculin Test is not indicated due to Low risk factors, please document here: _____

	Yes	No
1. Head, Ears, Nose Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		

Comments: _____

Medical information pertinent to routine child care and emergencies: _____

Is this child taking prescription medication on a daily basis for a chronic illness/condition? Yes ___ No ___

If so, indicate prescription: _____

Does the child have allergies? Yes ___ No ___

List Allergies and Reactions _____

Is child on a special diet? Yes ___ No ___

Describe Restrictions _____

(Attach additional sheet if more space needed to document)

I have examined the above named child and reviewed his/her health history and immunization records.

I feel that child is able to participate in normal activities: Yes ___ No ___

Currently appears to be free from contagious or communicable disease : Yes ___ No ___

Is receiving appropriate health care and age appropriate immunizations: Yes ___ No ___

Medical Care Provider

Signature of Provider

Date

Address

Town, State, Zip

Telephone