UCCAC Head Start/Early Head Start Physical Exam Record

Main Office Fax# 845-339-3567

LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	SEX ☐ M ☐ F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN

To the best of my knowledge this child is free from communicable diseases and free to participate in all program related activities. YES or NO

TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE	
CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
inches (%)	lbs/oz (%) BMI for age (%)	

Anticipatory Guidance Provided ☐ Yes ☐ No Fluoride Varnish Applied ☐ Yes ☐ No

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Blood Pressure (age 3+)			Mouth/Teeth/ Oral Health Assessment			Genitalia		
Skin						Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Hearing Assessment		
Nose			Abdomen			Vision Assessment		

Vision Acuity (Age 3+)		Right	Left	Both	Hearing Screening (Age 4+)		Frequency (Hz)	Right (db)	Left (db)
Date		/	/	/	Date		1000 Hz	dB	dB
							2000 Hz	dB	dB
Test Type					Test Type		3000 Hz	dB	dB
							4000 Hz	dB	dB

Hemoglobin/Hematocrit			Lead		
DATE	**HGB/HCT result**	☐ No Risk Anemia	DATE	**Lead Level (mcg/dl)**	☐ No Risk
TREATMENT	FOLLOW-UP		Result required for blood lead screening performed between 24 & 72 months as per Medicaid		

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ
DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE	

Dyslipidemia Screening

SCREENING ☐ Risk Factors Present ☐ No Risk

Immunizations (Attach Immunization Record)

Child is UTD on all immunizations: ☐ Yes ☐ No

Is receiving appropriate health care and age appropriate immunizations according to NYS EPSDT schedule for well child care: Yes or No

Diagnosis/Abnormal Findings	Treatment/Restrictions/Recommendations for School

Food Allergy	Special Diet/Classroom Medication

MEDICATIONS REQUIRED AT SCHOOL

☐ Yes ☐ No (If yes; Physician Authorization Forms Needed)

TYPE OF MEDICATION AND PURPOSE

**RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America)
- Live in out-of-home placements
- Have, or are suspected to have, HIV infection
- Live with an adult with HIV seropositivity
- Live with an adult who has been incarcerated in the last five years
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes
- Have abnormalities on chest X-ray suggestive of TB
- Have clinical evidence of TB

Consult with your local health department's TB control program on any aspects of TB prevention and treatment

TO BE COMPLETED BY HEAD START STAFF

NAME OF STAFF COMPLETING 1ST REVIEW	SIGNATURE	POSITION	DATE
NAME OF STAFF COMPLETING 2ND REVIEW	SIGNATURE	POSITION	DATE

Referred for Follow-Up to:

HEALTH	MENTAL HEALTH	DISABILITIES	FAMILY SERVICES	EDUCATION	NUTRITION

Head Start Follow-Up & Notes

RECEIVED BY (PRINT NAME)	DATE RECEIVED