UCCAC Head Start/ Early Head Start

Phone: 845-339-3836	**Well Child Physical Exam**	**Main Office Fax: 845-339-3567**

EXAM DATE:	
Child's Name:	Date of Birth:
Head Start or Early Head Start Center:	
Significant Health History:	
Allergies:	
Immunization Status: UTD Yes or No	(Attach immunization record)
Given today:	Next Scheduled Immunization:

Screening	Results	Comments
Height- inches (all ages)		
Weight- pounds (all ages)		
Blood Pressure- value (>3 yrs)		
Head Circumference (<2 yrs)		
Vision (all ages) document results or if child could not comply		
Hearing (all ages) document results or if child could not comply		
Hct. / Hgb (>9 months)		
Lead(12m & 24m & <6 yr not previously tested)		
TB Date/Results (as required)		TB skin testing**: (please circle)** **Indicated not indicated low risk**
Dental: A) Visible caries and/or oral infection		**Yes or No**
B) Possible caries and /or oral infection		**Yes or No**
C) Teeth and tissues healthy		**Yes or No**

Any Dietary restrictions? Yes or No, Please describe:

Physical Examination	Normal	Abnormal	Comments
General Appearance			
Head			
Skin			
Eyes			
Ears			
Nose/Throat			
Heart			
Respiratory			
Hernia			
Gastrointestinal			
Genitourinary			
Muscular/Skeletal			
Neurological			
Developmental (anticipatory guidance)			
Behavior/Mental Health (anticipatory guidance)			

Please fill in all Yes or No ***blood work and TB questions above and below. ---------- <u>This is required for licensing of HeadStart/Early Head Start</u>. We will contact you for missing information if you leave any blanks unanswered. Thank you.***

Child is able to participate at Center and currently appears to be free of contagious or communicable disease:	**Yes or No**

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

Provider Name (please print):		Next Exam:
Provider Signature:	Phone:	Fax:
Clinic Name:		

Please stamp with office stamp

Parent's Name:	Phone:
Health Specialist:	Date:

UCCAC Head Start/ Early 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, Hearing and TB Risk Assessment**
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 participate in the program every child **must** have all of the required screenings listed above.

If you have any questions, please feel free to contact me at 339-3836 ext. 108.

Thank you for your cooperation,
Health Specialist

Child's Name: _____ Date of Birth:_____

For children not up to date with immunization schedule please complete the following questions:

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

Are there medical contraindications to immunization for this child? Yes or 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 or attach a printout of the child's immunization record which includes the month/date/year for each dose.

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