# UCCAC Head Start/Early Head Start Physical Exam Record

Main Office Fax# 845-331-0270

| 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 |
|---|---|---|---|---|
| Date | | / | / | / |
| Test Type | | | | |

| Hearing Screening (Age 4+) | | Frequency (Hz) | Right (db) | Left (db) |
|---|---|---|---|---|
| Date | | 1000 Hz | dB | dB |
| | | 2000 Hz | dB | dB |
| Test Type | | 3000 Hz | dB | dB |
| | | 4000 Hz | dB | dB |

### Hemoglobin/Hematocrit

| DATE | HGB/HCT result | ☐ No Risk Anemia |
|---|---|---|

| TREATMENT | FOLLOW-UP |
|---|---|

### Lead

| DATE | Lead Level (mcg/dl) | ☐ No Risk |
|---|---|---|

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 |
|---|---|
| | |