JEFFERSON COUNTY HEAD START

Serving Jefferson, Clear Creek, Gilpin, and Park counties

PHYSICAL EXAMINATION

							<u> </u>		WAIVII I	4/\						
TE T	CHILD'S NAME:							CENTER/CLASS:					BIRTHDATE:			
PARENT TO COMPLETE	Illnesses/Accidents/Problems/Concerns since last visit:								Today I have a question about:							
					то в	E COMPLET	ED E	зү н	EALTH	CA	RE PR	OVIDER				
Aller	Allergies:										Current Medications:					
Temp	Temp Puls			BP/			Hei	ght _	%	% Weight% BMI			ВМІ			
Head Start must follow Colorado State EPSDT standards. If blood lead level was done at 9-12 & 24 months and HGB/HCT was done before this exam, we can use those results.									Child Health History: History of birth injury, abnormal growth/development, congenital defects?							
Screening Test Perfo				` '				ate								
HGB/HCT □ Yes				gm/dl Dormal Abnormal					Significant acute or chronic medical problems?							
Lead Risk: [□ Yes		mcg/dL □ Normal □ Abnormal					Significant behavior/emotional concerns?								
TB Skin Test □ Yes				□ Positive □ Negative												
Risk: 🗆 Yes 🗆 No 🗆 No 🗆 Neg					ative				Speci	ial d	iet requi	rements?				
Hearing Screen MHZ R L 4000									Any concerns regarding child's growth or weight? Do the child's activities need to be modified because of the above or other circumstances?							
Vision Screen 20/ 20/																
Development: Circle any areas of concern									Immunizations given today:							
	Adaptive/Cognitive Language/Communication Gross Motor Social/Emotional Fine Motor									Immunizations completely up to date for age: □ Yes □ No If no, please describe plans to bring child up to date:						
0,00	o motor	Coolai	, L	A	1 1110	iviotoi							<u>.</u>			
Behavior										sia	of Immuni	ization must be				
Ment				<u> </u>				1	A signed Colorado Certificate of Immunization must be submitted to Jefferson County Head Start with this evaluation.							
Phys	ical: eral appea	ron 00	N	Α	O 1			A			I hereb	y certify that the	above nan	ned child is in		
Skin	rance			Liverse				(initia	1/		ealth and is of n					
Head					Cardiovascular/Pulses				(IIIIIa	1)				as already noted.		
	(Cover/Ur	ncover)									ine ch	ild may fully part	icipate ili t	ne program.		
Ears					0 : 1:									ned child is up to		
Nose				0-:					(initia	l)	EPSDT					
Oropharynx/Teeth									,		screen	mys.				
	Neck Nodes				□ Neurologic □ □ Gait				SIGN	SIGNATURE OF HEALTH CARE PROVIDER:						
Desc	Describe abnormal findings and comments:									NAME OF CLINIC/OFFICE (PLEASE PRINT):						
								_	РНО	NE	NUMB	ER:				
EXA	M DATE:	:			NEXT EXAM:				IS THIS THE CHILD'S MEDICAL HOME? YES NO							

Return Fax: 720-898-0664