

JEFFERSON COUNTY HEAD START
Serving Jefferson, Clear Creek, Gilpin, and Park counties

PHYSICAL EXAMINATION

Prior to enrollment in Jefferson County Head Start, all children are required to have a physical examination. ***The following tests/screenings are required: height, weight, vision, hearing, tuberculosis test/results, lead test/results and anemia test/results.*** Please help us to make sure your child is receiving all required tests/screenings, so that your child will be healthy and ready to learn. This physical examination form must be completed by your family health care provider.

CHILD'S NAME: _____ BIRTHDATE: _____ CENTER/CLASS: _____ INSURANCE: _____

SECTION 1 - PHYSICAL ASSESSMENT

	NORMAL	ABNORMAL	REFER	NOT EXAMINED
General Appearance				
Head				
Skin				
Eyes/Strabismus				
Ears/Nose				
Teeth				
Neck/Nodes				
Chest/Lung				
Cardiovascular				
Musculoskeletal				
Neuro/Reflexes				
Abdomen				
Genitals				

SECTION 2 - MEASUREMENTS

Temp _____ Pulse _____ BP _____ / _____
Height _____ % _____ Weight _____ % _____ BMI _____

SECTION 3 - IMMUNIZATION STATUS

Immunizations given today: _____
Immunization completely up to date for age: Yes / No
Comments: _____

A Colorado Certificate of Immunization must be completed with this evaluation and submitted to Jefferson County Head Start.

SECTION 4 - REQUIRED TESTS FOR HEAD START

Our Federal Program MUST follow Colorado State EPSDT standards. If blood lead was done at 12 & 24 months and HbG/HCT was done before this exam, we can use those results. Please fill in all blanks for required tests

Screening Test	Result	Date	Comments
Anemia <small>(Completed by MD) Test Type: HGB/HCT</small>			
Tuberculosis <small>Risk: Yes/No</small>			
Lead <small>Risk: Yes/No</small>			
Vision <small>Test type:</small>			
Hearing <small>(Not required) Test type:</small>			

SECTION 5 - CHILD HEALTH HISTORY

- History of birth injury, abnormal growth/development, congenital defects? _____
- Significant acute or chronic medical problems? _____
- Significant behavior/emotional abnormality? _____
- Does the child's activities need to be modified because of the above or other circumstances? _____
- Allergies? _____
- Current medications? _____
- Special diet? _____

I hereby certify that the above named child is in good health and is of normal physical and emotional maturity for age except as already noted above. The child may fully participate in the program.

SIGNATURE OF HEALTH CARE PROVIDER: _____ NAME OF CLINIC/OFFICE (PLEASE PRINT): _____ PHONE NUMBER: _____

Date of most recent exam: _____

Yes No Is this the child's medical home?

Next appointment: _____