Rockingham County Head Start

Physical Examination

Child's Name: _____DOB: _____Date of Exam: _____

Dear Provider: Our Federal Program MUST follow North Carolina State EPSDT standards. If test were done prior to this physical, we can use those results. We must have the required tests filled in.

REQUIRED TESTS

B/P _____date_____ HCT/HGB: _____date_____ BLOOD LEAD LEVEL: _____ date _____

Tuberculosis: _____date_____ Sickle Cell: _____date_____

SCREENING RESULTS:

Development/ Behavior:	Vision:	Hearing:
Speech:	Strabismus:	Dental:

PHYSICAL EXAM RESULTS:

Head:	Eyes:	Ears:
Nose:	Throat:	Neck:
Skin:	Chest:	Lungs:
Abdomen:	Genital:	Bones/Joints:
Nervous System:	Muscular System:	
Height: Weight:	Heart:	

Allergies/Asthma_____

_____

_____

Dietary Concerns/Restrictions: _____

_____

Physician Specific Concerns/Referrals: _____

_____

_____

On the basis of my findings as indicated and my knowledge of this child: (s)he is free from contagious and communicable disease, is receiving health care under the appropriate schedule set by the AAP and is able to participate in day care. (S)he has received, or will receive on the above * date, age-appropriate immunizations in accordance with NC Public Health Law.

Doctor's Name (please print): _____

Doctor's Address: _____

_____

Doctor's Signature: _____ Date: _____