

Sequatchie Valley Head Start - P.O. Box 769, South Pittsburg, TN 37380
WELL CHILD PHYSICAL EXAMINATION FORM

To be completed by Head Start Staff:

Check payer source: TN Care _____ Other Insurance _____ Head Start _____

Relevant information from Health History: _____

Child's Name: _____ D.O.B. _____ Center: _____

Parent/Guardian: _____

To Be Completed by Health Care Professional:

Height: _____ Weight: _____ Age: Years _____ Months _____ Blood Pressure _____ HGB/HCT _____

Blood Lead screening: _____ Vision: _____

Hearing: _____

Note other tests here, if indicated: _____

Check appropriate box.	"N" for normal.			"A" for abnormal.	"NE" for not examined.	Describe any abnormal finding(s).
	N	A	NE			
General appearance, posture, gait						
Speech						
Skin						
Eyes: External						
Optic fundi						
Cover Test						
Ears: External & canals						
Tympanic membranes						
Nose, mouth, pharynx						
Teeth						
Heart						
Lungs						
Abdomen (including hernias)						
Genitalia						
Bones, joints, & muscles						
Neurological examination						
<i>Developmental screening:</i>						<i>Please attach screening tool, if used.</i>
Gross motor function						
Fine motor function						
Communication skills						
Cognitive						
Self help skills						
Social skills						

General statement of child's physical status; include any recommended treatment & follow-up needed. Note if child has any existing atypical condition and if any limitations or special considerations exist for the classroom.

Please check if child is being treated for any of the following conditions:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Behavioral condition |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Underweight | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional condition |
| <input type="checkbox"/> High lead levels | <input type="checkbox"/> Overweight | <input type="checkbox"/> ADHD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear/hearing problem | <input type="checkbox"/> Other; please specify _____ | | |

Health Care Professional's Name (PRINT): _____

Health Care Professional's Signature: _____

Date of exam: _____ Original - HSO 1st Copy - Center file 2nd copy - health care professional

excel | Drive:forms/health/child physical