CardinalServices
Easterseals Northern Indiana Network Member

Kosciusko County Head Start/EHS
811 S Buffalo Street Warsaw, IN 46580
574-267-2451 • FAX 574-267-1998 • 800-315-2308

Physical Exam Form

NAME: _____**DOB** _____ **Date of exam**: _____

ALLERGY: *DRUG/ FOOD/other*_____

***For Food Allergy**, attach a prescription indicating the **food product eliminated and the substitution** needed!

Please complete the indicated health screenings today. If a particular screening is not available at your site, kindly refer parents to the KCDH Well Child Clinic (269-5152) Screenings are available to our participants at no cost Thank You. Head Start Health Coordinator/EHS Specialist

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Height _____ Weight _____ Head Circumference _____ (Complete if child is under age two.)

Blood Pressure _____ (Complete if child is over age two.)

Visual Acuity *Right *Left

Hearing Screen *Right *Left

***Subjective assessment until age three unless problems occur.**
After age three-objective, standard screening method required.

Hemoglobin Screen _____mg/dl (Annually, start 9- 12 months.) **If ordered, check this box** ☐

Lead Level _____ Date of exam _____ **If ordered, check this box** ☐

LEAD: *CHILD* MUST HAVE AT LEAST ONE BLOOD LEVEL *TO MEET HEAD START REQUIREMENT. .* ***ANY LEAD LEVEL DRAWN AFTER AGE 2*** *WILL SUFFICE. ENTER DATE OF EXAM. EPSDT and EARLY HEAD START REQUIRES* ***BLOOD LEVEL AT*** ***1 year AND 2years.***

Examination	*WNL*	*Needs Treatment*	*Examination*	*WNL*	*Needs Treatment*
General Appearance			Heart		
Skin			Rhythm /Rate		
Nose, Mouth, Pharynx			Lungs		
Teeth, Tongue			Elimination		
Eating / Feeding			Urinary		
Abdomen			Bowel		
Glands (Lymph, Thyroid)			Genitalia		
Eyes			Muscle Tone		
Ears			Strength		
General Behavior			Coordination		
Development: SPEECH, MOTOR, COGNITIVE, SOCIAL			Posture/Gait		
			Hip/ Joint Flexibility		
			Sleep Habits		
			Self Help Skills		

*Does this child have a **Current Diagnosis or Chronic disease? (N/A)** **Please explain…continue on next page for more space….**

_____

***Does this child have any **Physical limitations that prevent full participation, including outdoor activity?**
Indicate: (N/A) _____

* Does this child need M**edications or Therapy? Indicate: (N/A)** _____
While at **Head Start/EHS? (NA)** _____
Please, include complete instructions … Prescription needed only for OTC or sample medications. Intact pharmacy label needed for all others.

***Immunizations** received today: **(N/A)** _____
Did Hoosier Health Wise fund this Physical exam? **YES NO**

Date _____Signature of Provider _____

Print name and Phone # of provider (stamp).____

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Authorization for Use and Disclosure of Protected Health Information
AUTORIZACIÓN PARA OBTENER INFORMACIÓN MÉDICA O DENTAL

Child Information/ *Información de niño/a:*

Printed Name/ *Nombre del Niño*: _____

Date Of Birth/ *Fecha de Cumpleaños*:_____

Address/*Dirección*: _____

City/*Ciudad*: _____State/*Estado*_____ Zip/*Codigo*: _____

Telephone/*Telefono*: _____

Information To Be Released/ *Información que va a ser revelada*:

Date of Service/ *Fecha de Servicio*: _____ if known.

1. **DOCTOR: Please complete this KCHS/EHS Well Child Health Form (*ExamenFísico*) and send to:**

   Kosciusko County Head Start/Early Head Start
   811 S Buffalo St.
   Warsaw, IN 46580
   Attention: Health Coordinator
   Or FAX: 574-267-1998

2. **Release the following information/*Otra información necesaria:***
   _____

Thank You/*Gracias,*

Parent Signature/ *Firma:* _____Date/ *Fecha*: _____

Printed Parent/Guardian Name/*Nombre de Padre/Guardian*:_____

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