

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**: \_Terence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of exam**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ALLERGY: *DRUG/ FOOD/other*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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 | **\*Subjective assessment until age three unless problems occur.**  **After age three-objective, standard screening method required.** |
| Hearing Screen \*Right \*Left |
| Hemoglobin Screen \_\_\_\_\_\_mg/dl *(Annually, start 9- 12 months.)* If ordered, check this boxLead 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 9-12 months AND 2years.* | |

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| **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).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affordable Healthcare Starts with Breastfeeding!

