PLEASE RETURN TO:
Greater Opportunities
Head Start/ Early Head Start
44 W. Main St Norwich NY 13815
(607)334-7114/Fax 336-6958

HEAD START CHILD PHYSICAL EXAM

(PER CURRENT NYS EPSDT SCHEDULE)

Child's Name: ____ **Date of Birth:** ______/______/______

Medical Provider: (Print or Stamp name) ____

(Address & Phone #) ____

Date of Exam: _______/_______/_______ **HT**____________ **WT**___________ **Head Circ.** ___________ **BP** _______/_______

HGB or HCT Test Date_______/_______/______**Result**________

***One Year Lead Level Test Date**______/______/____**WNL YES**____**NO**_____

***Two Year Lead Level Test Date**______/______/____**WNL YES**____**NO**_____

NYS EPSDT Requires Lead testing at ages one and two years
LEAD REQUIRED BY HEADSTART BETWEEN TWO AND FIVE YEARS OLD IF NOT DONE AT AGE TWO

Medications Required at School? ☐ **Yes** ☐ **No**
Fluoride Prescribed? ☐ **Yes** ☐ **No**

TB at Risk? ☐ **Yes** ☐ **No**
Special Diet Required? ☐ **Yes** ☐ **No**
(If Yes specific instructions must be written on a script with provider signature)

Special Health Care Needs? ☐ **Yes** ☐ **No**
(If Yes please indicate what special provisions, if any, will be necessary)

Allergies? __________________________________

	NO CONCERN	CONCERN	REFER	COMMENTS
Physical Exam	_______	_______	_______	______________________________
Speech	_______	_______	_______	______________________________
Hearing	_______	_______	_______	______________________________
Vision R _____ /______ L _____ /______		_______	_______	______________________________
Teeth and Gums	_______	_______	_______	______________________________
Development/Behavior	_______	_______	_______	______________________________

**** NYS MANDATED IMMUNIZATIONS for participation if child is over one year**

TYPE	1ST	2ND	3RD	4TH	5TH
HEP B	** ____/____/____	** ____/____/____	** ____/____/____	____/____/____	____/____/____
DTaP	** ____/____/____	** ____/____/____	** ____/____/____	____/____/____	____/____/____
HIB	** ____/____/____	** ____/____/____	** ____/____/____	____/____/____	____/____/____
IPV	** ____/____/____	** ____/____/____	** ____/____/____	____/____/____	____/____/____
MMR	** ____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
VARICELLA	** ____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
PCV	____/_____/____	_____/_____/_____	____/_____/_____	____/____/_____	____/____/____

Please sign that child is free from contagious or communicable disease may participate in group day care and is up-to-date on a schedule of age appropriate preventive and primary health care. Parent received age appropriate discussion re: Anticipatory Guidance at this exam.

X____
Provider Signature

X______________________
Today's Date