GREATER OPPORTUNITIES

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HEALTH PROFILE (Physical)

Child's Name: _____ Date of Birth: _____ Center: _____

Physical Exam

Date of Exam: _____/_____/_____
☐ Exam Normal Specify any abnormalities: _____
_____
Height: _____ Weight: _____ Blood Pressure: _____
Vision-without glasses R_____ L_____ Vision-with glasses R_____ L_____
Hearing: R_____ L_____
Concerns: ☐ Vision ☐ Hearing Comments: _____

Health Specifics	**Comments**
Are there allergies? (Specify) ☐ Yes ☐ No	
Is medication required at school? (Specify drug and condition) ☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition) ☐ Yes ☐ No	
Is child prescribed fluoride: ☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention? ☐ Yes ☐ No	

Immunizations

☐ Immunization Record Attached ☐ Child is on a catch up schedule

Tests

Tuberculin Test Date: ___/___/___ Mantoux Results: ☐ Positive ☐ Negative _____ mm
TB Tests are at the physician's discretion.

****HGB/HCT** _____/_____/____ Result _____

****Lead Screening** (Include all dates and results)
1 year ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 year ____/____/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary
Most recent date of lead screening (if different from above):
_____/_____/_____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

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.

****On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No**

Provider Signature: _____ (Provider Stamp Below)
Provider Address: _____
Phone: _____ Fax:_____