Physical Health Assessment

Child Name: _____ Sex_____ DOB_____ Head Start Unit _____

Parent/Guardian: _____ Payment source: ( ) T-19 ( ) CHIP Program ( ) IHS ( ) Private Insurance ( ) Head Start

Exam date_____ Height _____ Weight _____ Vision _____ Hearing _____ HGB/HCT _____ BP_____

***REQUIRED: Lead screening - this must be a blood test (finger stick is acceptable)**

If one has not been completed prior to today one needs to be done at this time. **Please list** **Date:** _____ **Results:** _____

If the child has had one prior to today that is acceptable. **Please list** **Date:** _____ **Results:** _____

Health and developmental history (inclding assessment of both physical and mental health development): ☐ Yes ☐ No

Physical Assessment	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General appearance			Ears			Heart		
Posture/gait			Speech			Abdomen		
Skin			Nose/Mouth/Throat			(include Hernia)		
Lymph Nodes			Teeth			Genitalia		
Head			Glands			Back/Extremities		
Neck			Glands			Bone, Joint, Muscle		
Eyes			Lungs			Neurological		

Anticipatary guidance Given: ☐ Yes ☐ No
(inclusive of Injury and Violence prevention, Sleep positioning and Nutrition Couseling)

Seasonal or Medication Allergies:

Does this child take any medications? If yes please list them: _____

Has this child had Chicken Pox? _____ Yes - Date _____ _____ No

Is this child up to date on immunizations? _____ Yes _____ No **(Please attach immunization record)**

Comments/General Statement on child's physical status:	**Treatment Plan for Abnormal Findings**	☐ Follow Up Needed ☐ Treatment Completed ☐ Referral Where: _____

Physicians Signature: _____

Physicians Name/ Clinic (Printed): _____

Physicians/Clinic Address: _____

_____

_____

Physicians/Clinic Phone Number: _____

Return completed form to: **South Central Child Development, INC**
401 Walnut Street SW
Wagner, SD 57380
605-384-3683
Fax (if possible)# 605-384-5696