



CDS Lakeshore Head Start
 100 South Pine St. Suite 220
 Zeeland, MI 49464

PHYSICAL EXAM & ASSESSMENT

For Head Start Staff Use:

Center Name: _____

Advocate: _____

Date of Exam ___/___/___

Date of Birth: ___/___/___

Child's Name _____

Physician's Name _____ Phone () _____

Address: _____ City _____ State _____ Zip _____

<i>Please Check Appropriate Box</i>	Normal For Age	Abnormal	Refer for Evaluation	Not Evaluated	Comments
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
External Aspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Optic Fundoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cover Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Canal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
External	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen (include Hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bones, Joints, Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Help Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glands (Lymphatic/Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental (Teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Height: _____ - _____ Inch **Weight:** _____ lb _____ oz **BMI** _____

Blood Pressure: _____ / _____

Hematocrit: _____ % or **Hemoglobin** _____

Lead Test: _____ Normal Abnormal Refused

Hearing:

Left Ear: Pass Fail Unable

Right Ear: Pass Fail Unable

Vision:

Left Eye: Pass Fail Unable

Right Eye: Pass Fail Unable

All Screenings in this box required by Head Start

Allergies: _____ **Medications:** _____

CHRONIC CONDITIONS: (Check those that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Sickle Cell _____ | <input type="checkbox"/> Fetal Alcohol Syndrome _____ |
| <input type="checkbox"/> Neonatal Drug Addiction _____ | <input type="checkbox"/> Epilepsy/Seizure Disorder _____ | <input type="checkbox"/> HIV/AIDS _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Cerebral Palsy _____ | <input type="checkbox"/> Congenital abnormalities _____ |
| <input type="checkbox"/> None | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Other _____ |

ACUTE HEALTH ISSUES:

- | | Most recent occurrence | | Most recent occurrence |
|--|------------------------|---|------------------------|
| <input type="checkbox"/> Reactive Airway Disease | _____ | <input type="checkbox"/> Failure to Thrive | _____ |
| <input type="checkbox"/> Anemia | _____ | <input type="checkbox"/> Upper Respiratory Illness | _____ |
| <input type="checkbox"/> Meningitis | _____ | <input type="checkbox"/> Gastrointestinal Disturbance | _____ |
| <input type="checkbox"/> Convulsions/Seizures. w/o fever | _____ | <input type="checkbox"/> Fracture/Contusion | _____ |
| <input type="checkbox"/> Ear Infections | _____ | <input type="checkbox"/> Thrush | _____ |
| <input type="checkbox"/> Lead Poisoning | _____ | <input type="checkbox"/> Diaper Rash | _____ |
| <input type="checkbox"/> Intestinal parasites | _____ | <input type="checkbox"/> Conjunctivitis | _____ |
| <input type="checkbox"/> Head Injury | _____ | <input type="checkbox"/> Allergic Reaction | _____ |
| <input type="checkbox"/> Inadequate diet | _____ | <input type="checkbox"/> Other _____ | _____ |
| <input type="checkbox"/> Feeding/eating problems | _____ | <input type="checkbox"/> None of the above | _____ |

IMMUNIZATIONS: (Or attach a copy of their MCIR Record)

	1st	2nd	3rd	4th	5th	6th
HEP B						
DTaP/DTP						
HIB						
POLIO						
MMR						
VARICELLA						
PNEUMOCOCCAL						

TB Test Date: _____ / _____ / _____ Pos Neg (Not required) (To be done at doctor's discretion)

Comments/Recommendations/Referrals:

Physician Signature: _____ Date: _____