RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Early Learning Services
Head Start/Early Head Start Programs

Physical Examination

Child's Name: _____ Date of Physical Examination: _____

Date of Birth: _____

Head Start requires a complete CHDP equivalent health examination for entrance into the program.

CHDP Periodicity visit for:	1 Mos	2 Mos	4 Mos	6 Mos	9 Mos	12 Mos	15 Mos	18 Mos	24 Mos	30 Mos	3 Yrs	4 Yrs	5 Yrs

TB Risk Factor Assessment:	Blood Lead Risk Factor Assessment:
❑ Risk factors not present; TB skin test not required	❑ Risk factors not present ❑ Risk factors present

Hematocrit /Hemoglobin 9 Month 2,3,4 Years	Date:	Results:	Anemia: ❑ Yes ❑ No	Iron Supplements: ❑ Yes ❑ No	
Blood Lead Test: 12 and 24 Month If no record, perform	Date:	Results:	Blood Pressure:	Date:	Results:____ / ____
Tuberculin Skin Test	Date Given:	Date Read:	Results: ☐ Negative ☐ Positive	Chest X-ray Date:	Results: ☐ Negative ☐ Positive

Height: (%)	Weight: (%)	BMI:	Head Circumference:
Vision: Right – 20/_____ Left – 20/ _____		Strabismus: ❑ Pass ❑ Fail	Hearing: ❑ Pass ❑ Fail

Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested
Anticipatory Guidance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Developmental Screening			
Ears/Nose/Throat				Autism Spectrum Disorder Screening			
Seizures				Developmental Surveillance			
Mouth/Teeth Dental/Nutrition				Psychosocial/Behavior Assessment			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (Hernia)				Maternal Depression Screening			

Is the child cleared to enter preschool? ❑ Yes ❑ No

List any allergies, chronic conditions or special accommodations: _____

_____

List medications required at school (include medication name and dosage): _____

_____

Provider (Please print): _____ Signature: _____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____