Sequatchie Valley Head Start - P.O. Box 2212, Jasper, TN 37347

WELL CHILD PHYSICAL EXAMINATION FORM

To be completed by Head Start Staff:
Check payer source: **TN Care** ____ **Other Insurance** ____ **Head Start** ____

Relevant information from Health History:_____

Child's Name:_____ D.O.B. _____ Center: _____

Parent/Guardian: _____

To Be Completed by Health Care Professional:

Height: Weight: Age: Years Months Blood Pressure HGB/HCT

Blood Lead screening: Vision:

Hearing:

Note other tests here, if indicated:

Check appropriate box. "N" for normal. "A" for abnormal. "NE" for not examined.

	N	A	NE	Describe any abnormal finding(s).
General appearance,posture,gait				
Speech				
Skin				
Eyes: External				
Optic fundi				
Cover Test				
Ears: External & canals				
Tympanic membranes				
Nose, mouth, pharynx				
Teeth				
Heart				
Lungs				
Abdomen (including hernias)				
Genitalia				
Bones, joints, & muscles				
Neurological examination				
Developmental screening: Gross motor function				*Please attach screening tool, if used.*
Fine motor function				
Communication skills				
Cognitive				
Self help skills				
Social skills				

General statement of child's physical status; include any recommended treatment & follow-up needed. Note if child has any existing atypical condition and if any limitations or special considerations exist for the classroom.

Please check if child is being treated for any of the following conditions:

___Anemia ___Vision problems ___Low birth weight ___Behavioral condition
___Sickle cell anemia ___Underweight ___Asthma ___Emotional condition
___High lead levels ___Overweight ___ADHD ___Seizures
___Ear/hearing problem ___Other; please specify _____

Health Care Professional's Name (PRINT): _____

Health Care Professional's Signature: _____

Date of exam: _____ Original - HSO 1st Copy - Center file 2nd copy - health care professional

H-2 Z:\2018 Forms Manual Revision\Health