2545 North 29th St
Milwaukee, WI 53210
414-562-2929 ext. 2613
414-918-2743 fax

Head Start Physical Exam

nextdoor
— Stronger Families Through Education —

You may attach your physical form or electronic record report if desired.

CHILD'S NAME:_____DOB:_____ M___F___Exam date:_____

ALLERGIES:_____

Medications: _____

Food Allergies/Dietary Restrictions:_____

Ht: _____" Wt: _____# BP_____ Vision: R 20/___ L 20/___ □ pass □ fail □ untestable

Hearing: R___dB L___dB □ pass □ fail □ untestable

Hgb:_____ Lead:_____ Date (if different from visit):_____ Risk Factors assessed and lead not needed □

(Head Start/Medicaid Policy Requires lead testing annually for 3, 4, and 5 year olds in the city of Milwaukee)
Current Reference Level ≥5 requires education.

Please indicate any significant past medical history (surgery, prematurity, delays, therapies):

Exam Findings:	nl	See Note
Eyes		
ENT/Mouth		
Dental/Oral Health		
Cardiovascular		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Skin		
Neurological		
Development		

□ Fluoride Varnish Applied

Medical Condition/Problem/Need:	Treatment Plan:	Follow-up Needed by Head Start Staff?
		□ no □ yes, please indicate how we can help

Provider/Clinic Name, Address, and Phone (may stamp):

Immunizations: Circle those given today and attach a copy of the records:

IPV	DTaP	MMR	Flu
Hib	HBV	Varicella	
HAV	PCV		

I certify that I have examined the above child on this date and that he/she is able to participate in Head Start activities.

Provider Signature:_____ Date of exam: _____ Return to clinic in _____ months

Next Door Staff: _____ Revised 2/2018