Save the Children.

Medical History and Physical Examination Form

Child's Name:_____ Site:_____

Parent's Name:_____ Phone Number:_____

Sex: ☐ Male ☐ Female Date of Birth:___/___/___ Age:_____

ALLERGIES

☐ No known allergies

☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Codeine ☐ Other drugs:_____

☐ Food:_____

Personal Health History

Please describe any chronic medical conditions and diagnoses (includes severe, life threatening reactions, nutritional, mental health & disability concerns), the most recent occurrence, and any currently prescribed medications:

_____

_____

_____

_____

Current Medications:_____

** An Individual Health Care Plan must be completed for any chronic health, nutrition and/or mental health concerns.*

Growth Assessment

Blood Pressure:_____/_____ □ Normal □ Refer Height:_____ □ Normal □ Refer

Weight:_____lbs_____ozs □ Normal □ Refer Head Circumference _____ (0-24months)

Physical Exam:

	Normal	**Referred to:**
Speech		
Skin		
Eyes/Vision		
Ears/Hearing		
Mouth/Nose/Pharynx		
Teeth/Oral Health		
Heart		
Lungs		
Abdomen		
Genitourinary		

Bones, Joints, Muscles		
Glands (Lymphatic/Thyroid)		
Muscular Coordination		
Nutrition		

Early Head Start Only

	Normal	**Referred to**
Checked for Critical Congenital Heart Defect (Newborn only)		
Maternal Depression Screening—mother only (1month, 2 months, 4months, 6months)		
Developmental Surveillance (newborn-6months, 12 months, 15 months, 24months)		
Developmental Screening (9months, 18 months, 30 months		
Autism Screening (18 months & 24 months)		

Lab Results (Required for EPSDT):

Newborn Blood results (only for newborn): ☐ Positive ☐ Negative

Newborn Bilirubin: ☐ WNL ☐ High Treatment:_____

Lead Results:_____

Lead Risk Assessment: ☐ Passed ☐ Referred to:_____

Hemoglobin/Hematocrit:_____Indication of Iron Deficiency Anemia: ☐ Yes ☐ No

Needs Treatment: ☐ Yes ☐ No Specify:_____

Immunization History:

Immunization Record Reviewed: □ Yes □ No

Immunizations Given at This Time:_____

Anticipatory Guidance Provided (Parent Education):

☐ Emergency/911 Safety ☐ Gun Safety ☐ Drowning Prevention ☐ Chocking prevention

Save the Children.

☐ Care/Care Seat Safety	☐ Safe Sleep	☐ Shaken Baby Prevention	☐ Safe Bathing
☐ Passive Smoke	☐ Safety at Home/Child Proofing	☐ Sun Safety	☐ Pacifier Use
☐ Bottle Propping	☐ Infant Bonding	☐ Support Systems/Resources	☐ Child Temperament
☐ Meeting Milestones	☐ Establishing Routines	☐ Reading to the child	☐ Limiting Screen Time
☐ Positive Parenting	☐ Discipline/Behavior	☐ Independence	☐ Outdoor Play
☐ Supervision	☐ Other:_____		

Provider's Signature:

☐ This child may participate in Head Start / Early Head Start with NO health-related restrictions.

☐ This child may participate in Head Start/Early Head Start with the following health-related restrcitions:

_____

_____

_____

Date of Physical Exam :

_____ _____

Physician's Signature Date

_____

Printed Name

_____ _____

Office Phone: Office Address: