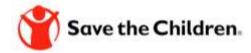


## Medical History and Physical Examination Form

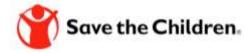
Child'	s Name:						_ Site:
Paren	t's Name:						Phone Number:
Sex:	☐ Male	☐ Female	D	ate of Birth:		_/	Age:
	RGIES known alle	ergies					
☐ Pei	nicillin [	☐ Aspirin	☐ Sulfa ☐	] Codeine		Other drug	gs:
□ Fo	od:						
Please nutriti		ny chronic me al health & dis			_	•	s severe, life threatening reactions, rrence, and any currently
	ndividual He						nutrition and/or mental health
Blood							□ Normal □ Refer
		osozs	□ INormai	□ Kefer	Hea	a Circumi	ference (0-24months)
Physi	cal Exam:			Named		Deferme	d 40.
Spec	ach .			Normal		Referre	a to:
Skin							
	s/Vision						
	Hearing						
	th/Nose/P	Pharyny					
	th/Oral He						
Hea							
Lung	_						
	omen						
	itourinary	7					



Safety

Dance Isinta Museles			
Bones, Joints, Muscles Glands (Lymphatic/Thyroid)			
Muscular Coordination			
Nutrition			
Tructicion			
Early Head Start Only			
	Normal	Referred to	0
Checked for Critical Congenital			
Heart Defect			
(Newborn only)			
Maternal Depression Screening—			
mother only			
(Imonth, 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)			
Newborn Blood results (only for newborn Newborn Bilirubin: $\square$ WNL $\square$ High T	•	J	
Lead Results:			
Lead Risk Assessment: □Passed □Refe	erred to:		
Hemoglobin/Hematocrit:	Indica	ition of Iron Def	iciency Anemia: □ Yes □No
Needs Treatment: □Yes □No S	pecify:		
Immunization History:			
Immunization Record Reviewed:   Yes	□ No		
Immunizations Given at This Time:			
Anticipatory Guidance Provided (Par	ent Educatio	n):	
☐ Emergency/911 ☐ Gun Safety	□ <b>(</b>	Drowning	$\Box$ Chocking

prevention



Office Phone:

☐ Care/Care Seat Safety	☐ Safe Sleep	☐ Shaken Baby Prevention	$\square$ 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	$\square$ Reading to the child	☐ Limiting Screen Time						
$\square$ Positive Parenting	☐ Discipline/Behavior	☐ Independence	☐ Outdoor Play						
$\square$ 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 restrictions:									
Date of Physical Exam:									
Physician's Signature		 Date							
Printed Name									

Office Address: