Source of Reimbursement
☐ Hoosier Healthwise
☐ Head Start ☐ Other

HEAD START PHYSICAL EXAMINATION

White Copy: Head Start
Yellow Copy: Central Office
Pink Copy: Doctor

Teacher _____ AM _____ PM _____

Child's Name _____ DOB _____

Parent/Guardian _____

Community Action Program, Inc. of Western Indiana
P.O. Box 188 • Covington, IN 47932 • 765-793-4881

Date of Exam _____

Child's Height _____ Weight _____

Blood Pressure _____

Hematocrit or Hemoglobin _____

Lead _____

Mantoux Date given _____

results _____ mm

IMMUNIZATIONS

	1	2	3	4	5
Influenza Yearly					
Rotavirus					
PCV 13					
DTaP/DT/Td					
IPV					
Varicella					
Hib					
Hep B					
MMR					
Hepatitis A					

PHYSICAL EXAMINATION/ASSESSMENT:	NORMAL FOR AGE	ABNORMAL	NOT EVAL.	COMMENTS (USE ADDITIONAL SHEET IF NEEDED)
General Appearance				
Posture, Gait				
Speech				
Head				
Skin				
Eyes: (1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
Ears: (1) External &Canais				
(2) Tympanic Membrane				
Nose, Mouth, Pharynx				
Teeth				
Heart				
Lungs				
Abdomen (include hernia)				
Genitalia				
Bones, Joints, Muscles				
Neurological/Social				
(1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				
Glands (Lymphatic/Thyroid)				
Muscular Coordination				
Other				

Physical health free of restrictions? Yes _____ No _____

If no, explain: _____

If a Follow-up appointment is necessary, give date: _____ Reason: _____

_____ EXAMINER'S NAME & TITLE

_____ EXAMINER'S SIGNATURE

_____ STREET ADDRESS

_____ CITY, STATE, ZIP

_____ PHONE

_____ DATE