ESC 19 HEAD START
SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

Child's Name:_____ Sex:_____ Date of Birth: _____

Head Start Center: Phone #: Classroom #

TO BE COMPLETED BY HEALTH CARE PROVIDER / EXAMINATION RESULTS

Height (%)	Weight (%) BMI for age (%)	Blood Pressure (age 3+)

EXAM	Normal for Age	Abnormal	Not Evaluated
Skin			
Head			
Neck			
Lymph Nodes			
Eyes			
Cover/Uncover			
Ears			
Nose			
Mouth			
Teeth			
Throat			
Chest			
Lungs			
Heart			
Back			
Abdomen			
Genitalia			
Neurologic			
Gross/Fine/Motor Ability			
Psychosocial / Behavioral Health			
Speech			
Other			

Vision Acuity Exam	Passed	Failed	Not Evaluated
Vision Results			

Hearing Screening	Passed	Failed	Not Evaluated
Hearing Results			

Hematocrit/Hemoglobin	Lead
Date	Date
HGB(g/dl)	Lead Level(mcg/dl)

Medicaid requires at least one lead level between 24 & 72 months

Screening of TB Risk Factors

____Risk factors NOT present: TB SKIN TEST NOT REQUIRED

____Risk factors present: Mantouz TB skin test performed

Date given	Results	Non Significant	DATE READ

DATE OF CHEST X-RAY ____NORMAL ____ABNORMAL

Dyslipidemia Screening

_____ Risk Factors Present ____ No Risk

IMMUNIZATIONS

_____ IMMUNIZATIONS ARE UP TO DATE GIVEN TODAY: _____ YES _____ NO

Abnormal Findings/Diagnosis	Treatment/Recommended Follow-Up or Results	Date

☐ Child is cleared to attend Region 19 Head Start for the school year

PHYSICAL EXAMINATION ADMINISTERED BY (PRINT):	SIGNATURE	DATE OF EXAM
ADDRESS		PHONE NUMBER

Confidential

REVISED June 2023