KidZCommunity

PHYSICAL EXAM FORM

Child's Name: _____ DOB: _____ School Site: _____

Head Start requires a complete EPSDT equivalent health exam **every year**. Documentation is a mandated requirement for **all** screenings. If results for screenings are not included, Head Start must resubmit for screening information.

Periodicity visit for: **1-2** Mo. **3-4** Mo. **5-6** Mo. **7-9** Mo. **10-12** Mo. **13-15** Mo. **16-23** Mo. **30** Mo. **2** Yr **3** Yr **4** Yr **5** Yr

Date of Exam: _____ Insurance: _____

PLEASE COMPLETE/CHECK ALL BOXES ACCORDING TO PERIODICITY

Assessment	No Concern	Concern	Concerns/Diagnosis – Recommendations (Referral / No Referral)
History and Physical Exam			
Oral Assessment/Dental Referral			**Fluoride: ☐Discussed ☐Prescribed ☐Referred ☐Sealants**
Nutritional Assessment			
Developmental Assessment			
Clinical Observation-Vision			
Non Audiometric			
Autism Screening			
Existing Health Issues			

Testing Results	Concern/No Concern/ Not Required/ Deferred	Comments: Suspected concerns/Referrals (required for follow-up)
Blood Pressure	N/A	
Snellen or Equivalent	Normal N/A	☐ Deferred until next exam (age appropriate) ☐ Referral:
Audiometric	Normal N/A	☐ Deferred until next exam (age appropriate) ☐ Referral:
Hemoglobin or Hematocrit	g Hgb. / N/A % Hct. / N/A	Results: ☐ Anemic ☐ Not Anemic ☐ **Deferred** ☐ **Not Eligible**
TB Exposure Risk Assessment Questionnaire	Risk Low Risk	If At Risk – PPD Test: ☐ Yes ☐ No If No PPD-Reason:
TB Test	Negative Positive	☐ Deferred ☐ Positive-Plan_____ Preschool classmates At Risk: ☐ Yes ☐ No
Growth Assessment/ BMI-	Ht: Wt:	BMI-for-age Percentile: _____% ☐ Overweight ☐ Underweight
Head Circumference		
Lead Screening Assessment	Risk Low Risk	Blood Draw: ☐ Yes ☐ No ☐ Deferred until next exam (when age appropriate)
Blood Lead Test: ***(1yr., or 2 yr. or current testing)***	Blood Lead Results: _____ (Past or Current Levels)	Follow-up Needed: ☐ Deferred ☐ Not eligible
Risks of Second Hand Smoke Discussed with parent(s)	Yes No	

Immunizations Status:

☐ Given Today: ☐ DPT/DTaP ☐ IPV ☐ Hib ☐ Hep B ☐ PCV ☐ MMR ☐ MMRV ☐ Var Other_____

☐ UTD (none needed at this time) ☐ Additional Immunizations due by: _____(date)

I have determined that this child is up-to-date on all age appropriate preventive and primary heath care, including TB and blood lead assessments. I have indicated any concerns regarding this child's primary health care. This physical exam can be considered complete as per EPSDT, no further screening or testing needed.

Doctor Signature: _____ ***Date***: _____ ***Exam date:***_____

Please print or use stamp:

Physician/Medical Group Name: _____*Phone Number:* _____