YWCA ST. LOUIS HEAD START/ EARLY HEAD START
Physical Exam Form

eliminating racism
empowering women
ywca

CHILD'S NAME _____ DOB _____ DATE OF EXAM _____

PPD per risk assessment
Results Pos/Neg
Date: _____
TB Household Contacts?
Y ☐ ☐ N

Blood Pressure (36 + months):
_____
Systolic/Diastolic

PHYSICAL EXAM (ALL INFORMATION MUST BE WITHIN 12 MONTHS OF DATE THAT FORM IS SIGNED)

HEIGHT _____ WEIGHT _____ %TILE _____

SYSTEM	NORMAL	ABNORMAL	FOLLOW-UP / COMMENT
SKIN			
EENTS			
MUSCULAR SKELETAL			
GASTROINTESTINAL			
GENITAL-URINARY			
NEUROLOGICAL			
RESPIRATORY			
CARDIOVASULAR			

VISION TEST	R L B		
HEARING TEST	R L B		
LEAD	Date	Results	Doctor Refused ☐
HEMOGLOBIN	Date	Results	Doctor Refused ☐
MEDICATIONS:			
ALLERGIES:			

IMMUNIZATIONS ADMINISTERED

DTAP#	IPV#	HIB#	MMR#	HEPB#	PCV#	VARICELLA#	OTHER:
NEXT IMMUNIZATION DUE:							

Was a Dyslipidemia Assessment performed? ☐ YES ☐ NO Comment _____

Does the child require any specialized care? ☐ YES ☐ NO If yes, explain _____

_____

I have examined the above-named child and verify that this child's medical history and current state of health are ☐☐ are not satisfactory for participation in Head Start/Early Head Start program.

PHYSICIAN'S NAME (please print) _____ PHONE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

Revised 05/2019 MTW