# EARLY & HEAD START PHYSICAL EXAM/ASSESSMENT

Child's Name: _____ Gender:_____ Birthdate:_____

WCC __0-1 month __2 month __4 month __6 month __9 month __12 month __15 month __18 month __24 month

Physical ___3 years ___4 years ___5 years

*** Date of Physical Examination/Assessment: _____**

| Physical Exam/Assessment | Normal for Age | Abnormal | Not Evaluated |
|---|---|---|---|
| General appearance | | | |
| Skin | | | |
| Posture/Gait | | | |
| Eyes | | | |
| Ears, Nose, Mouth, Pharynx | | | |
| Teeth (EHS-Oral screening) | | | |
| Glands (Lymphatic/Thyroid) | | | |
| Lungs | | | |
| Heart | | | |
| Abdomen | | | |
| Genitalia | | | |
| Bones, Joints, Muscles | | | |
| Neurological | | | |
| Muscular Coordination | | | |
| Speech | | | |
| Social | | | |
| Other | | | |

| Measurement/Screenings | Results |
|---|---|
| Height | |
| Weight | |
| Head Circumference(under 12 mon) | |
| BMI( over 2 years) | |
| Blood Pressure (over 3 years) | |
| Hearing –tool used_____ | |
| Vision –tool used _____ | |
| * Lead (Required age 12 & 24 months; yearly after 3yrs) Date done: | |
| * Hgb or HCT (Required age 12 & 24 months and once after 3 years) ) Date done: | |
| TB (If at risk) | |
| Sickle Cell (newborn screen) | |
| Are there any limitations or health Conditions including allergies, daily medication or dietary restrictions? If Yes, please list:_____ _____ _____ _____ | |

**If there are any abnormal findings, please list and include any recommended follow-up:** _____

****ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS***

Exceptions to Immunization requirement pursuant to 5104.014 ORC (please include Names of requirement diseases against which the child has not been immunized and whether it is because the immunization contraindicated, not medically appropriate for the child's age, or declined by the parent)

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of Ohio Revised Code. Please note disease above and sign: Signature of Parent:_____ Date: _____

- ✓ The above named child has been examined and is in suitable condition for participation in group care. Child is up-to-date according to EPSDT guidelines.
- ✓ The above named child has been immunized in accordance with the requirements of section 5104.014 of Ohio Revised Code (please note any exceptions above)

Signature of examiner:_____

Name/Title of examiner: _____ Phone: _____

Address: _____

Revised 5/19/2018-cjhealth

Please Stamp and Sign