CESA #11 Head Start

Head Start Physical Examination

Date of Exam:

TO BE FILLED OUT PRIOR TO PHYSICAL

Child's Name:	**DOB:**
Head Start Center:	**Phone:**
Center Address:	**Fax:**

TO BE COMPLETED BY THE HEALTH PROVIDER

Height	**Weight**	**Head Circumference**	**Blood Pressure**

Vision		**Hearing**	
R:	**L:**	**R:**	**L:**

Hgb/Hct: ***If indicated by Health Provider:*** **Urine:** **Lead:**

Speech Assessment Findings: ☐ Normal ☐ Referral

Comment(s):

Developmental Screening Findings: ☐ Normal ☐ Referral

Comment(s):

Immunizations Given Today:

Physical Findings of Significance: *(current health problems, medications, etc.)*

Referrals or Follow Up Needed:

Provider/Clinic Name *(print):*

Provider Signature:

Address:

Phone: