Charleston County School District Early Head Start / Head Start

Physical Examination

Child's Name: _____ DOB: _____ Date of Exam: _____ Agency/Center _____

Check Appropriate Well Child Assessment:

☐ **2 Mos** ☐ **4 Mos** ☐ **6 Mos** ☐ **9 Mos** ☐ **12 Mos** ☐ **15 Mos** ☐ **18 Mos** ☐ **24 Mos** ☐ **36 Mos** **Other:** _____

Dear Provider: Our Federal Program MUST follow South Carolina State EPSDT standards.

REQUIRED TESTS

Height or Length _____ in/cm
Weight _____ lbs_____ oz or _____ kilograms
Head Circumference (under 2 yrs.) _____in/cm
Blood Pressure Date:_____ Results:_____

Sensory Screenings

(*When possible record vision 20/30, 20/40, etc. at ages 3 & 4)*
Vision: Right eye _____ Left eye _____

Hearing: *Right Ear* ☐ Pass ☐ Fail *Left Ear* ☐ Pass ☐ Fail

Hgb and/or Hct (due at age 1 yr) Date:_____ Results:_____
Blood Lead Level 1st_____ Results:_____ 2nd _____ Results:_____

MD ORDER: Finger-stick HGB/HCT or Blood Lead may be completed by HS Nurse if necessary- NO ____ YES_____

PHYSICAL EXAM RESULTS:

Head:	Eyes:	Ears:
Nose:	Throat/Mouth:	Lymph nodes:
Skin:	Chest:	Speech:
Abdomen:	Genitalia:	Diet:

Nervous System:	Muscular:
Behavior/Development:	Heart/Lungs:

SC IMMUNIZATION CERTIFICATE IS REQUIRED TO ATTEND HEAD START. Next imm. appt. _____

Physician Specific Concerns/Referrals: _____
_____

☐ The child may participate in Head Start/Early Head Start with **NO** health-related restrictions.
☐ The child may participate **with these restrictions**: _____
☐ Next physical appt _____ ☐ Next follow- up appt _____ for _____

Provider_____ Address:_____Phone_____

Examining Health Professional: _____/_____/_____
PRINT NAME SIGNATURE DATE

Form completed by: (if different) _____/_____/_____
PRINT NAME SIGNATURE DATE

Consent to Fax this form: _____Date: _____ Center Fax #_____
PARENT'S SIGNATURE

Rev. 3/9/2014

HSPS 1304.20

"COMMITTED TO KEEPING CHILDREN HEALTHY"