Community Services
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# Head Start

*"Building partnerships, changing lives"*

## Head Start/Texas Health Step Physical Form

Child's Name/Nombre de Nino | Birthdate/Fecha de Nacimiento

**Section 1: Physical Exam/Assessment**

| | Normal | Abnormal |
|---|---|---|
| Skin | ☐ | ☐ |
| EENT | ☐ | ☐ |
| Heart | ☐ | ☐ |
| Lungs | ☐ | ☐ |
| Abdomen | ☐ | ☐ |
| Neuromuscular /social | ☐ | ☐ |
| Genitalia | ☐ | ☐ |

Comments:

Doctor's Name:

Address:

Phone Number:

**Section 2: Standard Tests & Measurements**

Blood Pressure _____/_____ **(WNL: ☐ Y ☐ N)**

Height _____ Weight_____ **(WNL: ☐ Y ☐ N)**

*HGB or HCT _____ Test Date_____ **(WNL: ☐ Y ☒ N)**
**(Required when result from age (1) Texas Health-step Physical is not known)**

*Lead Level _____ Test Date _____ **(WNL: ☐ Y ☒ N)**
**(Required when result from age (2) Texas Health-step Physical is not known)**

Vision: Rt. 20/ Lt. 20/ **(WNL: ☒ Y ☐ N)**

Hearing: 1000/2000/4000 freq. @ 25 db. **(WNL: ☐ Y ☒ N)**

Child is up to date on schedule of age appropriate preventative and primary health care: (Texas Health Step Physical) & Immunizations ☐ Yes ☒ No

Allergies (Med/Food etc.): _____

Please indicate any significant past medical history (Surgeries, Diabetes, PT, OT, etc.)

Please indicate if there are any concerns regarding mental health or cognitive delays.

Is child currently being treated for any medical conditions? Please state diagnosis and medications: (Asthma, Seizures, ect.)

I certify that I have examined the above child on this date and that he/she is able to participate in Head Start activities.

**Physical Exam Date: _____**

**Doctor/Health Care Provider Signature: _____Date:_____**