Community Services
CSNT
of Northeast Texas, Inc.

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Head Start

"Building partnerships, changing lives"

Head Start 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 _____/_____

Height _____ Weight_____

*HGB or HCT (12mon.) _____ Date_____

*Lead Level (2Y/O)_____ Date _____

***Head Start requires the lead test to be done after 2nd birthday and Hgb at 12 months.**

Vision _____ Hearing _____
Left eye 20/_____ Right eye 20/_____

Child is up to date on schedule of age appropriate preventative and primary health care:

_____Yes _____ No

Allergies: _____

Please indicate any significant past medical history (Surgeries, 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 medication,

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

Doctor/Health Care Provider Signature: _____Date:_____

Date of Exam: _____