Child Physical Exams Record
Early Childhood Council of the San Luis Valley
San Luis Valley Early Head Start
(719) 937-4010 Fax (719)496-0664

Child's Name ______________________ DOB ____________ Center ______________

Parent/ Guardian ________________________ Phone Number ______________________

Please Complete: ☐ Medicaid ☐ CHP+ ☐ Private Insurance ☐ No Insurance

Please mark well child check:
☐ 2 mo. ☐ 4 mo. ☐ 6 mo. ☐ 9 mo. ☐ 12 mo. ☐ 15 mo. ☐ 18 mo. ☐ 24 mo. ☐ 36 mo. ☐ Other ______

Head Start Federal Regulations require that each child have an EPSDT exam that conforms to the state requirements.

Required Data **Please Complete**

B/P (3+years)______OFC(< 2years)__________
Ht____________ Wt_________

Visual Acuity Left 20/______ Right 20/______
Strabismus Normal_____ Referral Made______

Hearing by OAE/audiometer Normal________
Will recheck__________ Referral made________

Speech Normal_______ Referral made________

Please attach copy of the most recent Immunization Record

Is this child *free from* reportable communicable disease? Yes______ No_______ If NO, please explain ______________________________

Required Systems Review **Please mark "yes" if normal or "no" if not and/or if you made a referral**

	Yes	No	Refer		Yes	No	Refer
Head				Glands/ Nodes			
Skin				Heart			
Eyes				Lungs			
Ears				Abdomen			
Mouth/ Nose				Extremities			
Throat				Spine			
Teeth				Neuro			

Tests **Please include lab value and if normal**
Date of Test_______________________
Hematocrit ______or Hemoglobin__________ Normal (Y/N)___
Lead Level___________ Normal Yes____ No______
Name of other test(s) done_______________________
Value_______ Normal Yes______ No___________

Please answer the questions below, using the back side of the form if more space is needed.

Does this child:

Have any illnesses, chronic or disabling problems? **No**____ **If Yes**, please list ______________________

Have any known allergies? **No**____ If **Yes**, please list ______________________

Need any medications at home? **No**__ **If Yes**, please list______________________

Need any medications while at school? **No**__ If, **Yes**, please list______________________

Have any special dietary needs, including food allergies? **No**__ If **Yes**, please list ______________________

Have any developmental delays or abnormal growth patterns? **No**___ If **Yes**, please explain ______________________

Do you have any other concerns? **No**__ If **Yes**, please list______________________

Was age appropriate Anticipatory Guidance provided? **No**____ **Yes**____

MEDICAL PROVIDER SIGNATURE______________________ Date of Exam__________ Date Form Signed________

MEDICAL PROVIDER PRINTED NAME______________________ DR'S PHONE NUMBER______________