



ANN WINDLE SCHOOL FOR YOUNG CHILDREN

Head Start Student Physical

Child's Name: _____	Date of Birth: _____	*AGE _____
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PHYSICIAN PLEASE NOTE:

Please Complete entire student physical. **Starred items (*) are required by Head Start** and recommended by the American Academy of Pediatrics for children 3-5 years. **Hemoglobin/Hematocrit, Blood Lead Level, Blood Pressure, Hearing and Vision.**

Date of Exam:	*Blood Pressure:	*Height:	*Weight:	*Hearing: Type of Test: _____ R _____ L _____	*Vision: Type of Test _____ R _____ L _____
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*HEMATOCRIT/HEMOGLOBIN	Date: _____	Result: _____
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*BLOOD LEAD LEVEL	Date: _____	Result: _____
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PHYSICAL EXAM	NORMAL FOR AGE?		DESCRIPTION
	YES	NO	
General Appearance			
Posture, Gait			
Speech			
Head			
Skin			
Ears			
Eyes			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen (include hernia)			
Genitalia			
Bones, Joints, Muscles			
Neurological/Social 1. Gross Motor _____ 2. Fine Motor _____ 3. Communication Skills _____ 4. Cognitive _____ 5. Self-Help Skills _____ 6. Social Skills _____			
Glands (Lymphatic/Thyroid)			
Muscular Coordination			
Other			

General Statement of Child's Physical Status: _____

Print Provider Name _____ **Signature:** _____ **Date:** _____

FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE