CAP AGENCY
COMMUNITY ACTION PARTNERSHIP
SERVING SCOTT CARVER & DAKOTA COUNTIES

Head Start

May return via fax at:
651-322-3555

Physical Exam Form

1302.42(b)(i)

CHILD'S NAME	DATE OF BIRTH	CLASSROOM

Early and Periodic Screening Diagnostic and Treatment (EPSDT) exam required.
These items are required by Federal Head Start regulations and the MN C&TC Schedule of Age-Related Screening Standards.

***Exam Date:** _____ *** **Periodicity Visit for (Check):** ☐ 3yrs ☐ 4yrs ☐ 5yrs

VISION

LEA/HOTV	SPOT
R: 10/_____ **L:** 10/_____ ☐ Pass ☐ Refer	☐ Pass ☐ Refer

Comments:
☐ Wearing corrective lenses

HEARING

OAE: ☐ Pass ☐ Refer

PURETONE	500(25)	1000(20)	2000(20)	4000(20)
R	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer
L	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer

Comments:
☐ Ear tubes in place

BLOOD PRESSURE	_____/_____	**HEIGHT** **WEIGHT**	_____in _____lbs ___oz
HEMOGLOBIN	_____ g/dL	**LEAD**	_____ µg/dL
Date of Service*: *Prior Date Acceptable ☐ Today/Pending ☐ Completed		Date of Service*: *Prior Date Acceptable ☐ Today/Pending ☐ Completed	

PHYSICAL EXAM

EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL
Skin	☐	☐	Chest	☐	☐
Nodes	☐	☐	Cardiovascular	☐	☐
Head	☐	☐	Abdomen	☐	☐
Eyes	☐	☐	Genitourinary	☐	☐
Ears	☐	☐	Neurological	☐	☐
Nose	☐	☐	Musculoskeletal	☐	☐
Mouth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Motor Ability	☐	☐

ORAL EXAM

Were teeth examined? ☐ Yes ☐ No
Fluoride Applied ☐ Yes ☐ No
Referred to Dentist ☐ Yes ☐ No
Comments:

IMMUNIZATIONS Please attach Immunization Record

Given today:
☐ DTaP/DT ☐ Polio ☐ MMR ☐ HIB ☐ Hep A ☐ Hep B
☐ Varicella ☐ Other: _____ ☐ None
Immunization Status:
☐ Up-to-Date ☐ Catch-Up Schedule ☐ Parent Declined

OTHER CONDITIONS

Asthma ☐ Yes ☐ No Current issue: ☐ Yes ☐ No
or RAD ☐ Yes ☐ No
Does this child have rescue medication? (inhaler/neb or other)
☐ Yes ☐ No
☐ No medications are required at Head Start for asthma/RAD
Please attach an Asthma Action Plan for this child.

Allergies ☐ Yes ☐ No
Describe:
Does this child have rescue medication? (Epi-Pen or other)
☐ Yes ☐ No
☐ No medications are required at Head Start for allergies
Please attach Allergy/Anaphylaxis Action Plan for this child.

Food Restrictions ☐ Yes ☐ No ***Not food Preferences***
☐ Lactose Intolerant
If yes, you will receive a Minnesota Department of Education Special Diet Statement Form to complete and return to Head Start.

Other Conditions that require special care while at Head Start? (medications or accommodations)
☐ Yes ☐ No Describe:

Please attach Care Plan for the condition listed.

Social Emotional/Developmental Concerns
☐ Yes ☐ No ☐ Speech concern
Please Describe:

***Is the child up to date on a schedule of age-appropriate health care? ☐ **Yes** ☐ **No** If no, what is not complete:

Referrals/Follow-Up ☐ **Yes** ☐ **No** **If yes, to whom?** **Appointment Date:**

Health Provider's Contact Information and Signature

Provider Name (Print):	Clinic Name/Address (Stamp acceptable)
Provider Signature:	
Date Form Completed:	
Phone Number:	

Parent – Sign below: I hereby give my permission to the Provider/Clinic listed above to release information regarding the medical care provided to my child to CAP Agency Head Start. I reserve the right to revoke my permission at any time and this release will automatically expire one year after the date of my signature.

_____ Parent/Guardian Signature

_____ Date