



THIS FORM MUST BE SIGNED & VERIFIED BY A MEDICAL PROFESSIONAL

EARLY & HEADSTART PHYSICAL/ASSESSMENT

Child's Name: _____ **Gender:** _____ **Birthdate:** _____

WCC: ___0-1month ___4month ___6month ___9month ___12month ___15month ___18month ___24month

Physical: ___3years ___4years ___5years

Date of Examination/Assessment: _____

Physical Exam/Assessment	Normal For Age	Abnormal	Not Evaluated
General appearance			
Skin			
Posture/Gait			
Eyes			
Ears, Nose, Mouth, Pharynx			
Teeth (EHS-Oral Screening)			
Glands (Lymphatic/Thyroid)			
Lungs			
Heart			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological			
Muscular Coordination			
Speech			
Social			
Other			

Measurements/Screenings	Results
Height	
Weight	
Head Circumference (under 12 months)	
BMI (over 2 years old)	
Hearing – tool used _____	
Vision – tool used _____	
Lead – (required age 12 & 24 months; yearly after 3 years old) Date done: _____	
Hgb or HCT (required age 12 & 24 months and once after 3 years) Date done: _____	
TB (if at risk)	
Sickle Cell (newborn screen)	
Are there any limitations or health conditions including allergies, daily medication or dietary restrictions? If yes, please list: _____ _____ _____	

If there are any abnormal findings, please list and include any recommended follow-up:

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exemptions to Immunization requirement pursuant to 5104.014 ORC (please include Names of required diseases against which the child has not been immunized and whether it is because the immunization contraindicated, not medically appropriate for the child's age, or declined by the parent):

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of Ohio Revised Code. Please note disease(s) above and sign:

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to child: _____

The above name child has been examined and is in suitable condition for participation in group care. The child is up-to-date according to EPSDT guidelines. The above named child has been immunized in accordance with the requirements of section 5104.014 of Ohio Revised Code (please not any exceptions above). **Signature/Office Stamp**

Signature of examiner: _____ Date: _____

Name/Title of examiner: _____

Address: _____