CDS Lakeshore Head Start
100 South Pine St. Suite 220
Zeeland, MI 49464

PHYSICAL EXAM & ASSESSMENT

For Head Start Staff Use:

Center Name: Advocate:

Date of Exam ___/___/___

Date of Birth: ___/___/____

Child's Name _____

Physician's Name _____ Phone ( ) _____

Address: _____ City _____ State _____ Zip _____

Please Check Appropriate Box	Normal For Age	Abnormal	Refer for Evaluation	Not Evaluated	Comments
General Appearance	☐	☐	☐	☐	
Posture, Gait	☐	☐	☐	☐	
Speech	☐	☐	☐	☐	
Head	☐	☐	☐	☐	
Skin	☐	☐	☐	☐	
Eyes	☐	☐	☐	☐	
External Aspect	☐	☐	☐	☐	
Optic Fundoscopic	☐	☐	☐	☐	
Cover Test	☐	☐	☐	☐	
Ears	☐	☐	☐	☐	
Canal	☐	☐	☐	☐	
External	☐	☐	☐	☐	
Nose, Mouth, Pharynx	☐	☐	☐	☐	
Abdomen (include Hernia)	☐	☐	☐	☐	
Genitalia	☐	☐	☐	☐	
Bones, Joints, Muscles	☐	☐	☐	☐	
Neurological/Social	☐	☐	☐	☐	
Gross Motor	☐	☐	☐	☐	
Fine Motor	☐	☐	☐	☐	
Communication Skills	☐	☐	☐	☐	
Cognitive	☐	☐	☐	☐	
Self-Help Skills	☐	☐	☐	☐	
Social Skills	☐	☐	☐	☐	
Glands (Lymphatic/Thyroid)	☐	☐	☐	☐	
Muscular Coordination	☐	☐	☐	☐	
Dental (Teeth)	☐	☐	☐	☐	

Height: _____-_____ Inch **Weight**: _____lb _____oz **BMI** _____

Blood Pressure: _____/_____

Hematocrit: _____% or **Hemoglobin** _____

Lead Test: _____ Normal Abnormal Refused

Hearing:
Left Ear: Pass Fail Unable
Right Ear: Pass Fail Unable

Vision:
Left Eye: Pass Fail Unable
Right Eye: Pass Fail Unable

All Screenings in this box required by Head Start

Allergies: _____ **Medications:** _____

CHRONIC CONDITIONS: *(Check those that apply)*

☐Heart Problems _____
☐Neonatal Drug Addiction_____
☐Kidney Disease _____
☐None
☐Sickle Cell_____
☐Epilepsy/Seizure Disorder _____
☐Cerebral Palsy _____
☐Asthma_____
☐Fetal Alcohol Syndrome_____
☐HIV/AIDS _____
☐Congenital abnormalities_____
☐Other _____

ACUTE HEALTH ISSUES:	Most recent occurrence		Most recent occurrence
☐Reactive Airway Disease	_____	☐Failure to Thrive	_____
☐Anemia	_____	☐Upper Respiratory Illness	_____
☐Meningitis	_____	☐Gastrointestinal Disturbance	_____
☐Convulsions/Seizures. w/o fever	_____	☐Fracture/Contusion	_____
☐Ear Infections	_____	☐Thrush	_____
☐Lead Poisoning	_____	☐Diaper Rash	_____
☐Intestinal parasites	_____	☐Conjunctivitis	_____
☐Head Injury	_____	☐Allergic Reaction	_____
☐Inadequate diet	_____	☐Other _____	_____
☐Feeding/eating problems	_____	☐None of the above	

IMMUNIZATIONS: *(Or attach a copy of their MCIR Record)*

	1st	2nd	3rd	4th	5th	6th
HEP B						
DTaP/DTP						
HIB						
POLIO						
MMR						
VARICELLA						
PNEUMOCOCCAL						

TB Test Date: _____/_____/_____ ☐ Pos ☐ Neg (Not required) (To be done at doctor's discretion)

Comments/Recommendations/Referrals:

Physician Signature: _____ Date: _____