Early Learning Indiana Child Care Partnership Early Head Start Physical Exam Form

Early Learning Indiana Early Head Start 1776 N. Meridian St. Indianapolis, IN 46202 phone 317-636-9197

Student Name_____ Date of Birth: _____

Examination		**Date of Exam:**_____
Height:	Weight:	Head Circ.:
Blood Pressure at 36mo:		
Hgb/Hct at 12 months:		Lead (12 and 24 months):
Vision Screening (Red Reflex and tracking if <3 yo) **Pass/Fail**		Hearing: Passed Newborn ABR **Yes/No**
Developmental Screening:		Additional Hearing Testing Indicated **Yes/No**

	Normal	**Abnormal Finding**	**Not Examined**
Appearance	☐	☐	☐
Head	☐	☐	☐
Eyes External Aspects	☐	☐	☐
Eyes Red Reflex/Cover Test	☐	☐	☐
Ears Internal Aspects	☐	☐	☐
Ears External Aspects	☐	☐	☐
Nose	☐	☐	☐
Mouth, Phaynx	☐	☐	☐
Heart	☐	☐	☐
Lungs	☐	☐	☐
Abdomen	☐	☐	☐
Genitalia	☐	☐	☐
Extremities, Bones	☐	☐	☐
Skin	☐	☐	☐
Neurologic	☐	☐	☐
Development			
Gross Motor	☐	☐	☐
Fine Motor	☐	☐	☐
Communication Skills	☐	☐	☐
Social Skills	☐	☐	☐
Self-help Skills	☐	☐	☐

Any **allergies**? ☐Yes ☐No If yes, please identify specific allergy below.

☐Medications_____ ☐Pollens ☐Food_____ ☐ Stinging Insects_____

Medications: Please list all prescription and over-the-counter medications the child is currently taking.

Medical Conditions: Additional documentation/follow-up is required for the items selected below

☐Anemia ☐Asthma ☐Cerebral Palsy ☐Epilepsy/Seizure Disorder ☐Diabetes ☐Failure to Thrive

☐Gastro-intestinal Disturbance ☐Heart Problem ☐High Lead ☐Hearing Problems ☐Speech Delay

☐Respiratory Disorder ☐Vision Problems ☐Other:_____

Comments:_____

_____**Referred to** ☐ First Steps ☐ Other_____

Name of Physician (print)_____

Address_____ Phone_____

Signature of Physician_____ Date_____