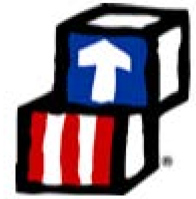
Palo Verde Unified School District
Head Start Program
295 E. Chanslorway, Blythe, Ca 92225
Phone (760)-922-8454 FAX (760)-922-3204



Physical Examination

Child's Name: ______________________________ Date of Physical Examination: ______________________

Date of Birth: ______________________________

Head Start requires a complete CHDP equivalent health examination for entrance into the program.

***Please make sure the Physical form is complete, including all Screenings.**	CHDP Periodicity visit for:	3 Yrs	4 Yrs	5 Yrs

TB Risk Factor Assessment: **Must be done once a year**
❑ Risk factors not present; TB skin test not required

Hematocrit/Hemoglobin: **12 Month or Current**	Date:	Results:	Anemia: ❑ Yes ❑ No	Iron Supplements: ❑ Yes ❑ No	
Blood Lead Test: **24 Month** If no record, perform	Date:	Results:	Blood Pressure:	Date:	Results:____ / ____
Tuberculin Skin Test	Date Given:	Date Read:	Results: ☐ Negative ☐ Positive	Chest X-ray Date:	Results: ☐ Negative ☐ Positive

Height: (%)	Weight: (%)	BMI:	Head Circumference:
Vision: Right – 20/________ Left – 20/ ________		Strabismus: ❑ Pass ❑ Fail	Hearing: ❑ Pass ❑ Fail

Examination Results	Normal for age	Abnormal (describe findings)	Not Tested	Examination Results	Normal for age	Abnormal (describe findings)	Not Tested
Anticipatory Guidance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Developmental Screening			
Ears/Nose/Throat				Autism Spectrum Disorder Screening (18 and 24 mos)			
Seizures				Developmental Surveillance			
Mouth/Teeth Dental/Nutrition				Psychosocial/Behavior Assessment			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (hernia)				Maternal Depression Screening			

Is the child cleared to enter preschool? ❑ Yes ❑ No

List any allergies, chronic conditions or special accommodations: ______________________________

____

List medications required at school (include medication name and dosage): ______________________________

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Provider (please print): ______________________________ Signature: ______________________________

Practice/Clinic Name: ______________________________ Phone Number: ______________________________

Address: ____

FORM NO. 4728T (Revised 09/18)