hamilton county esc
EARLY LEARNING PROGRAM
924 Waycross Road – Cincinnati Ohio 45240

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Head Start Physical Examination/Assessment Form

Parents: Head Start requires a physical exam for each child annually. Please return the completed form to Head Start office at the address above or fax the completed form to 513-589-3077.

Child's Name: _____ Sex: [] Male [] Female D.O.B.: _____

Parent/Guardian's Name: _____ Phone: _____

Address: _____ Zip: _____ Center: _____

Required Screenings:

Lead Test Results: _____ **Date Completed**_____ **HCT/HGB**: _____ **Date Completed**_____

Blood Pressure: _____/_____ **Height**: _____ **Weight**: _____ **Vision**: P / F **Hearing**: P / F

Type of Vision Screening: _____ **Type of Hearing Screening: _____**

TB test: (if child was born in a high-risk country or has travelled to a high-risk country in the last year.) **Does Not Apply** ☐
Date: _____ **Type**: _____ **Results**: _____

Name of Developmental Screening Tool Completed: _____Score: _____Date: _____

Recommendations: _____

Allergies: _____ **Chronic Conditions: _____**

Immunizations on Schedule? ☐ Yes ☐ No **(please attach copy of immunizations)**

Abnormal Findings/Diagnosis Developmental concerns	Plan of Action	Recommended follow-up and time frame

This child has been examined and is in suitable condition for participation in group care. The child has had the age appropriate immunizations required by Section 3313-671 of the Ohio Revised Code for admission to school; or has had the immunization required by Ohio Dept. of Health for infant and toddlers; or is to be exempted from immunizations for the following reasons:

_____

Practice/Clinic Name & Address: _____

Phone Number: _____ Fax Number: _____ Exam Date: _____

Physician (please print): _____ Physician Signature: _____