Lowndes County
Board of Education Head Start

CHILD HEALTH ASSESSMENT—FORM HEA 202

To the Health Care Provider: All items are required by Head Start. Please complete all sections and enter date if done previously. Provide comments on: services needed, suspect or atypical results and reasons services were not performed.

Child's Name:_____ **Sex**_____ **Date of Birth**____/____/____
Head Start Center_____ **Phone**_____
Address_____

TEST	RESULTS/DATE	COMMENTS
Present Age	Yrs._____ Mos_____	
Immunization Review	□ Up to date □ Immunizations needed	Please provide a copy of the blue slip.
Height_____(no shoes, to nearest 1/8 in) Weight_____(light clothing to nearest ¼ lb.)	□ Normal □ Abnormal	
Blood Pressure _____/_____	□ Normal □ Abnormal	
Pulse _____	□ Normal □Abnormal	
Hearing	□ Normal □ Abnormal	
Vision	□ Normal □ Referred for Eye Exam	
Dental Inspection	□ Normal □ Referred to Dentist	
Blood Lead	Results_____	
Hematocrit_____ Hemoglobin_____	□ Normal □ Abnormal	
Sickle Cell	□ Normal □ Abnormal	
Tuberculin (TB) Test	□ High Risk □ Low Risk	Results if High Risk _____mm
Urinalysis/Urine Screening	□ Normal □ Abnormal	

PHYSICAL EXAMINATION	+ = NORMAL	IF ABNORMAL- COMMENT
HEENT		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/TRUNK		
SKIN/LYMPH NODES		
NEURO/DEVELOPMENT		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT OR MEDICATIONS AND SPECIAL CARE(ATTACH ADDITIONAL SHEETS IF NECESSARY)

Next Appointment-_____

Signature of Physician: **Date:**