CMCCAA HEAD START PHYSICAL FORM

LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	SEX ☐M ☐F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN
AGENCY NAME	SITE NAME		

TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)		SIGNATURE
CLINIC NAME	TELEPHONE NUMBER	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
inches (%)	lbs/oz (%) BMI for age (%)	

Anticipatory Guidance Provided ☐Yes ☐No Fluoride Varnish Applied ☐Yes ☐No

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Blood Pressure (3+)			Mouth/Teeth/			Genitalia		
Skin			Oral Health Assessment			Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Hearing Assessment		
Nose			Abdomen			Vision Assessment		

Vision Acuity (Age 3+)		Right	Left	Both
Date		/	/	/
Test Type				

Hearing Screening (Age 4+)		Frequency (Hz)	Right (db)	Left (db)
Date		1000 Hz	dB	dB
Test Type		2000 Hz	dB	dB
		3000 Hz	dB	dB
		4000 Hz	dB	dB

Hemoglobin

DATE	HGB(g/dl)	☐ No Risk Anemia
TREATMENT	DATE OF FOLLOW-UP	

Lead

DATE	Lead Level (mcg/dl)	☐ No Risk

Medicaid requires at least one lead level between 24 & 72 months

*Hemoglobin and Lead level required to be complete physical

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	Non Significant ☐	Significant ☐	DATE READ

DATE OF CHEST X-RAY	Normal ☐	Abnormal ☐	RX DATE

Dyslipidemia Screening

SCREENING ☐ Risk Factors Present ☐ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No

DATE (OR AGE) NEXT PHYSICAL EXAM DUE

Diagnoses/Abnormal Findings	Treatment/Restrictions/Recommendations for School

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No (If yes; Physician Authorization Forms Needed)

TYPE OF MEDICATION AND PURPOSE

***Please return form to:**
CMCCAA Head Start
150 Lafayette, Rd.
Clarksville, TN 37042
Phone: (931) 896-1808 Fax: (931) 542-4616