



# Muskingum County Head Start- Pediatric Physical

|                              |               |
|------------------------------|---------------|
| Child's Name (print or type) | Date of Birth |
| Parent's Name                | Date of Exam  |

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Vision Screening - Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Hearing Screening - Right \_\_\_\_\_ Left \_\_\_\_\_

Hemoglobin or Hematocrit Results\* \_\_\_\_\_

Lead Screening RESULTS \* \_\_\_\_\_

**\*\* Ohio Law, Federal Requirement for ESPDT\*\***

This is to certify that I have examined this child and have found that:

- This child has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the state department of health for infants and toddlers or is to be exempted from these requirements for medical reasons.

| REQUIRED IMMUNIZATIONS (enter month, day and year) |        |        |        |        |        | Other Test | Date | Results     | Not indicated |
|--|--------|--------|--------|--------|--------|------------|------|-------------|---------------|
| VACCINE  | DOSE 1 | DOSE 2 | DOSE 3 | DOSE 4 | DOSE 5 |            |      | TB          |               |
| DTP/DTAP   |        |        |        |        |        |            |      | Sickle Cell |               |
| OPV/IPV  |        |        |        |        |        |            |      | Lead        |               |
| HIB  |        |        |        |        |        |            |      | Urinalysis  |               |
| MMR  |        |        |        |        |        |            |      | Other       |               |
| Hepatitis B  |        |        |        |        |        |            |      |             |               |
| PCV/Prevnar  |        |        |        |        |        |            |      |             |               |
| Varicella  |        |        |        |        |        |            |      |             |               |

|                | NORMAL | ABNORMAL | COMMENTS  |
|----------------|--------|----------|---|
| Well nourished |        |          | List any handicap, allergy or special health condition of child.  |
| Well developed |        |          |   |
| Skin           |        |          |   |
| Head           |        |          |   |
| Eyes           |        |          |   |
| Ears           |        |          |   |
| Nose           |        |          |   |
| Mouth          |        |          |   |
| Teeth          |        |          |   |
| Neck           |        |          |   |
| Chest          |        |          |   |
| Heart          |        |          |   |
| Abdomen        |        |          |   |
| Genitalia      |        |          | IS THIS CHILD UP-TO-DATE ON A SCHEDULE OF AGE-APPROPRIATE PREVENTATIVE AND PRIMARY HEALTH CARE? YES _____ NO _____<br>IF NO, PLEASE SPECIFY:<br><br>NEXT WELL VISIT IS DUE: _____ |
| Extremities    |        |          |   |
| Neurological   |        |          |   |

- Based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease and is in suitable condition to receive child day care.

|                                  |                               |
|----------------------------------|-------------------------------|
| Name of Physician (please print) | Telephone Number<br>( )       |
| Street Address                   |                               |
| City, State and Zip Code         |                               |
| Physician's Signature            | Date of Physician's Signature |