Reach Dane/ Head Start 2096 Red Arrow Trail, Fitchburg, WI 53711 (608) 275-6740 **fax: 608-275-6756**

PHYSICAL EXAMINATION

Label Here
Child's Name _____
Program _____
PY _____

Sex: M F Date of Birth: _____

1. Height _____ Weight _____ Blood Pressure _____
2. Vision: Both _____ R. Eye _____ L. Eye _____ Glasses: Yes ____ No _____
3. Hearing (audiometry) Normal _____ Abnormal _____ Comment _____
   (tympanometry) Normal _____ Abnormal _____ Comment _____
4. Immunization History: *If immunization(s) not to be administered due to medical reason(s), specify:*

DPT	#1 _____	#2 _____	#3 _____	#4 _____	#5 _____
POLIO	#1 _____	#2 _____	#3 _____	#4 _____	
HIB	#1 _____	#2 _____	#3 _____	#4 _____	
PCV	#1 _____	#2 _____	#3 _____	#4 _____	
HEP B	#1 _____	#2 _____	#3 _____		
MMR	#1 _____	#2 _____			
VARICELLA	_____	If had the disease (Date/Yr) _____			

As indicated: Date/result UA _____ TB _____ Hct/Hgb _____ Sickle Cell _____

5. Allergies _____ Does the child have a milk allergy? N Y substitute:_____
6. Medication(s) _____
7. **Medicaid policy requires lead testing at around 12mo & 24mo (or once between 3-5yrs if no previous test is documented).**
   Date of most recent blood lead test: (mm/dd/yy) _____ result _____

EXAMINATION - To Be Done By Physician or Nurse Practitioner

1.

	WNL	ABNL	Describe Abnormal Findings
Cooperation, Appearance, Posture, Gait			
Speech			
Eyes			
Ears: Canals & TM			
Nose, Mouth, Pharnyx, Teeth			
Neck			
Lungs			
Heart (if murmurs**)			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological			
Other			

**Is dental prophylaxis needed? ☐ Yes ☐ No If yes, please provide prescription: _____

2.

Problem/Needs	**Treatment Plan**	**Follow – Up Arranged**	
		Yes	No
		Yes	No

A. Physical Activity: ☐ Unrestricted ☐ Restricted B. Diet: ☐ Unrestricted ☐ Restricted

Explain: _____

3. I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

MD/PA or HealthCheck Provider Signature _____ Printed Name _____ Date of Examination _____

Please Print Address of Clinic and Telephone Number Clearly