YVEDDI
YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.

Head Start

Physical Examination/Well Child Check

Child's Name: _____ Date of Examination: _____

Date of Birth: _____

Hematocrit/ Hemoglobin	Date:	Results:	**Anemia:** ☐Yes ☐No	**Iron Supplements:** ☐Yes ☐No
Blood Lead Test	Date:	Results:	**Blood Pressure:** /	Date:
TB Skin Test	Date Given: Date Read:	Results: ☐Negative ☐Positive	**Vision:** Left – 20/	Right – 20/
Height: in	**Weight:** lb	**BMI:**	☐ Underweight (<5%) ☐ Normal (5% - 85%) ☐ Overweight (>85%)	**Hearing:** ☐Pass ☐Fail

Physical Examination: *To be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering state), a certified nurse practitioner, or a public health nurse meeting the standards for the EPSDT program.*

Examination Results	Normal for age	Abnormal (describe findings)	Not Tested	Examination Results	Normal for age	Abnormal (describe findings)	Not Tested
Anticipatory Guidance				Teeth, Mouth			
General Appearance				Heart			
Posture, Gait				Lungs			
Speech				Abdomen			
Head				Genitourinary			
Skin				Musculoskeletal			
Eyes				Neurological			
Ears				Developmental			
Nose, Pharynx				Psychosocial			

List any allergies, chronic conditions or special accommodations: _____

_____

List medications required at school (include medication name and dosage): _____

_____

Is the child cleared to enter Head Start? ☐Yes ☐No

Provider (please print): _____ **Signature:** _____

Practice/Clinic Name: _____ **Phone Number:** _____

Address: _____