HEAD START • EARLY HEAD START
Child Care Partnership
"A Comprehensive Birth to Five Program"

Tel (670) 664-3751/68 • Fax (670) 664-3760 • PO Box 501370, Saipan MP 96950

PHYSICAL EXAMINATION FORM

Child's Name:	D.O.B:	Gender: ☐Male ☐Female
Parent(s)/ Guardian(s):	Contact No.:	Medical Insurance No.:

SECTION 1: Child Birth Health History (To be completed by the Parent/Guardian)

Type of Delivery: ☐ Natural ☐ C-Section	Was the child born premature? ☐Yes ☐No	If yes, by how many weeks?	Child Birth Height (cm):	Child Birth Weight (kg):

Complications at Birth:

Were there any complications associated with this delivery (pre-term, fetal distress, etc.)? ☐ Yes ☐ No *If YES, please describe:*

Did baby have any problems at birth? ☐ Yes ☐ No *If YES, please describe:*

Did the baby have any observable defects: ☐ Yes ☐ No *If YES, please describe:*

Did mother have any health problems during pregnancy? ☐ Yes ☐ No *If YES, please describe:*

Has your child ever been hospitalized or operated on? ☐ Yes ☐ No *If YES, please describe:*

SECTION 2: Other SCREENING RESULTS and REQUIRED TESTS

Blood Pressure Check

Note: This is a required screening for all children ages *3 years old and above.*

Results: ___________________

☐Pass ☐Fail/ Refer

Hemoglobin/ Hematocrit

Note: This is a required screening for all children *9 months old and above.*

HGB Results: ______________

HCT Results: ______________

☐Pass ☐Fail/ Refer

Tuberculosis Screening & Testing

Note: This is a required screening for all ages. If child has already completed TB screening within the last 12 months please indicate the last test date and results.

Test Date: Results:

If not, please check appropriate box.

☐ Child is NOT at-risk of tuberculosis

☐ Child is AT-RISK of tuberculosis.

PPD is required. Please indicate child's results below.

Test Date: Results:

Lead Screening & Testing

REQUIRED: Lead Screening Risk Assessment:
(Perform between 9-12 months and at 24 months)

Check appropriate box.

☐ Child was tested for lead at the age of 12 and/or 24 months.
IF NO, please answer the following question below.

Child is at risk to lead poisoning.
☐ Yes ☐ No

Child has a sibling/ relative who has lead poisoning. ☐ Yes ☐ No

Has child moved from a foreign country or from a major metropolitan area within the last 12 months? ☐ Yes ☐ No

IF YES to any, please complete screening.

Test Date: ________ Results: ____ _______________

Vision Screening

Note: *If the physician does not have appropriate equipment to complete this section, please leave blank.*

Right Eye: _________________
☐Pass ☐Fail/ Refer

Left Eye: _________________
☐Pass ☐Fail/ Refer

Both Eyes Result: ___________
☐Pass ☐Fail/ Refer

Hearing Screening

Note: *If the physician does not have appropriate equipment to complete this section, please leave blank.*

Right Eye:
☐Pass ☐Fail/ Refer

Left Eye:
☐Pass ☐Fail/ Refer

Height & Weight Assessment

Note: This is a required screening for all ages.

Date of Screening: ___________________________

Height(cm): ________________

Weight(kg): ________________

Head Circumference *(for children ages birth -3 years old)* :_______

Behavior Screening (ASQ:SE)

Did the child complete Ages & Stages Questionnaire- Social Emotional? ☐ Yes ☐ No **If yes, please attach the completed questionnaire to this examination form.**

Developmental Screening (ASQ-3)

Did the child complete Ages & Stages Questionnaire- 3rd Edition? ☐ Yes ☐ No **If yes, please attach the completed questionnaire to this examination form.**

SECTION 3: Physical Exam Results

Head: ☐Normal ☐Abnormal	Teeth: ☐Normal ☐Abnormal	Heart: ☐Normal ☐Abnormal	Nose: ☐Normal ☐Abnormal

Oral: ☐Normal ☐Abnormal	Lymph Node: ☐Normal ☐Abnormal	Skin: ☐Normal ☐Abnormal	Chest: ☐Normal ☐Abnormal
Abdomen: ☐Normal ☐Abnormal	Muscular Coordination: ☐Normal ☐Abnormal	Speech: ☐Normal ☐Abnormal	Lungs: ☐Normal ☐Abnormal

SECTION 4: The following questions will help us learn more about the child. Please answer each of the following questions. If you answer YES to any of the following question in Section 4, please complete Section 5.

Section 4a: Check additional medical problems for this child:
☐ Seizures ☐ Diabetes ☐ Anemia ☐ Whooping Cough ☐ Eczema ☐ Other medical problems, describe ____________

Section 4b: Does the child have any allergy? ☐ Yes ☐ No *If YES, please complete section 4b.1 and section 5.*	**Section 4b.1**: Type of Allergy		
	Medication		
	Food		*If yes, please list alternate diet for food allergy:*
	Others		

Section 4c: Does the child have difficulty chewing or swallowing? ☐Yes ☐No
If yes, please offer dietary recommendation: ☐ Pureed ☐Mechanical: ___ Level 1 ___Level 2 ___Level 3

Section 4d: Does the child have a feeding tube? ☐Yes ☐No
If yes, please list alternate diet recommendation:

Section 4e: Does the child need a nutritional supplement due to lack of food intake? ☐Yes ☐No	*How much?*	*How often?*

Section 4f: Is child on a special diet for a medical condition? (e.g. diabetes, phenylketonuria (PKU)) ☐Yes ☐No
If yes, please explain:

Section 4g: List and explain any Dietary Restriction:
☐N/A

Section 4h: Does your child take vitamins/minerals/home remedies/herbal products? ☐Yes ☐No *If yes, specify:*

Section 5: Child Health Care Plan – ONLY NEEDED IF YES TO ANY QUESTIONS IN SECTION 4

Diagnosis: (check all that apply)
☐ Asthma ☐Diabetes ☐ Allergy ☐Eczema/ Skin Condition ☐Anemic ☐Seizure ☐Other:

Needed Accommodation

Diet or Feeding:	*Classroom Activities:*
Naptime/ Sleeping:	*Toileting:*
Outdoor Activities:	*Others:*

Routine Care

Medication to be Given at Center:	**Schedule/Dose (when and how much)**	**Route:**	**Reason Prescribed:**	**Possible Side Effects:**

Emergency Care

Call Parents/ Guardian if the following symptom presents:

Call 911 (Emergency Medical Service) if the following symptoms are present:

Take these measures while waiting for parents/guardian or medical help to arrive:

Name of Doctor/ Physician:	*Date:*
Clinic:	*Contact No.:*

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Immunization Record

To be completed by child's Health Provider

CHILD NAME	DATE OF BIRTH	GENDER
		☐ Male ☐Female
PARENT/ GUARDIAN NAME	**MAILING ADDRESS**	**CONTACT NO.**

VACCINE	PLEASE INDICATE THE DATE OF IMMUNIZATION (MONTH/DAY/YEAR)					REASON CHILD DID NOT COMPLETE SHOT OR NEXT APPOINTMENT DATE
	First	Second	Third	Fourth	Fifth	
Diphtheria, Tetanus, Pertussis (DTaP)						
Inactivated Poliovirus (IPV)						
Measles, Mumps, Rubella (MMR)						
Haemophilus influenza Type B (Hib)						
Hepatitis B (Hep B)						
Varicella						
Hepatitis A (Hep A)						
Pneumococcal (PCV)						
Rotavirus (RV)						
COVID-19 Vaccination (optional)						
Flu Influenza (one of two doses yearly)						

STATUS OF REQUIREMENTS:

☐ All Requirements are met.
☐ Currently up-to-date, but more doses are due later. **Needs FOLLOW-UP.**

EXEMPTION:

If a child cannot or should not receive a particular immunization, check one of the following reasons and specify in comments section.
☐ Has had disease (attach physician's note). For Rubella only a serologic test is a valid exemption.
☐ Allergic to ______________________________ (specify allergen).
☐ Parent will not consent (Attach parent refusal form).

CERTIFICATION OF IMMUNIZATION RECORD

I hereby attest that I have seen documents of all the above noted immunizations the child received prior to enrollment in Head Start/ Early Head Start- Child Care Partnership Program.

NAME	SIGNATURE	DEPARTMENT/AGENCY	DATE OF COMPLETION

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Dental Examination Form

To be completed by child's Health Provider

CHILD NAME	DATE OF BIRTH	GENDER
PARENT/ GUARDIAN NAME	**MAILING ADDRESS**	**CONTACT NO.**

CURRENT ORAL HEALTH STATUS	
Does the child have any teeth with untreated decay?	☐ Yes (Decay) ☐ No (Decay Free)
Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?	☐ Yes ☐ No
Any treatment needs?	☐ Yes, urgent. ☐ Yes, not urgent. ☐ No treatment needs.
Is this clinic the child's dental home?	☐ Yes ☐ No If no, please provide dental home clinic:

ORAL HEALTH CARE SERVICES DELIVERED DURING VISIT

Diagnostic/ Preventive Services		Counseling/ Anticipatory Guidance	Restorative/ Emergency Care	
Examination	☐ Yes ☐ No	Check one: ☐ Yes ☐ No If yes, please provide recommendation for support and services.:	Fillings	☐ Yes ☐ No
X-Rays	☐ Yes ☐ No		Crowns	☐ Yes ☐ No
Risk Assessment	☐ Yes ☐ No		Extractions	☐ Yes ☐ No
Cleaning	☐ Yes ☐ No	**Referral to Specialty Care**	Emergency Care	☐ Yes ☐ No
Fluoride Varnish	☐ Yes ☐ No	☐ Yes ☐ No If yes, please specify specialist:	Other (please specify):	
Dental Sealants	☐ Yes ☐ No			

FUTURE ORAL HEALTH CARE SERVICES

All treatment completed?	Next Recall Date: (Month/ Year)	Comment:
☐ Yes ☐ No		
More appointment needed for treatment?	**If yes: Approximate number of appointments needed:**	**Next appointment:**
☐ Yes ☐ No		Date: Time:

ADDITIONAL INFORMATION FOR PARENTS, HEAD START STAFF, AND MEDICAL PROVIDERS:

ORAL HEALTH PROVIDER'S CONTACT INFORMATION AND SIGNATURE

NAME	SIGNATURE	DEPARTMENT/AGENCY	DATE OF COMPLETION