Choctaw Nation Head Start
Physical Examination Form

Child's Name: _____ **Age:** _____ **Date of Birth:** _____

Name of Clinic/Doctor: _____ **Phone:** _____
PRINT NAME OF CLINIC/DOCTOR

***Source of Reimbursement*:** ☐ Sooner Care ☐ Indian Clinic ☐ Private Pay ☐ Insurance ☐ Head Start

Laboratory Tests

*If child does not have a documented Blood Lead test for the age of 2, and the child qualifies for SoonerCare, a Blood Lead Test must be obtained now to comply with Head Start Standards.		
Blood Lead Test	Date	Results

*If a child (age 3-4) is identified by Health Provider as "at risk", a Hematocrit/ Hemoglobin test must be completed per the Oklahoma EPSDT Requirements.
**If a child's risk status is "undetermined", a test is highly recommended.

Please circle child's risk status. →	At Risk	Not At Risk	Undetermined
Hematocrit or Hemoglobin Test — Date			
Hematocrit or Hemoglobin Test — Results			

Test / Screening

Type of Test / Screening	DATE	RESULTS
Height		
Weight		
Blood Pressure		
Vision		
Hearing		

IMMUNIZATIONS ARE UP-TO-DATE FOR AGE: ☐ YES ☐ NO
Details: _____

Does child have any allergies? ☐ YES ☐ NO **Details:** _____
(Example: Food, Medications, Latex, Adhesives, Environmental, etc.)

Does child have any Acute or Chronic Conditions? ☐ YES ☐ NO **Details:** _____
(Example: Asthma, Diabetes, Heart, Seizure, Anemia, Eczema, etc.)

Most Recent Occurrence: _____

PHYSICAL EXAMINATION

	NL	AB	NE	COMMENTS: NL=Normal AB=Abnormal NE=Not Examined
General Appearance				
Skin				
Eyes: Appearance, Symmetric				
Ears: External Canals Tympanic Membrane				
Nose				
Lips and Palate				
Teeth and Gums				
Tongue and Pharynx				
Neck and Nodes				
Chest and Breast				
Lungs				
Heart				
Abdomen (Hernia)				
Extremities				
Bones				
Muscles				
Joints				
Back				
Glands				

NEUROLOGICAL SOCIAL

	NL	AB	NE	COMMENTS: NL=Normal AB=Abnormal NE=Not Examined
Gross Motor				
Fine Motor				
Communication				
Cognitive				
Self-Help				
Social				

CHILD UP-TO-DATE WITH OKLAHOMA EPSDT REQUIREMENTS:
☐ YES ☐ NO
Details: _____

GENERAL STATEMENT: (Well Child, Child at Risk, etc.)
_____

RECOMMENDATIONS OR FOLLOW-UP:
_____

HEALTH PROVIDER'S SIGNATURE: _____ **DATE:** _____

Physical Exam must be completed within 90 days of Enrollment