

### Franklin County Head Start PHYSICAL EXAMINATION FORM

Program Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Fax \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Child's Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Parent's Name \_\_\_\_\_  
 Center Name \_\_\_\_\_

**IMMUNIZATIONS**

	DATE	DATE	DATE	DATE	DATE
DTP / Hib					
DTP / DTAP					
OPV / IPV					
Hib*					*ONE SHOT RE AFTER 15 MOS.
MMR			REQUIRED AFTER ONE YEAR OF AGE		
HEP-B / HBV**					**ONE SHOT RE AFTER 6 MOS.
PREVNAR					
VARIVAX		BCG (TB vaccine)		OTHER	

**MEDICAL HISTORY:** Allergies: \_\_\_\_\_  
 Diet Restrictions: \_\_\_\_\_  
 Current medications (dosage and frequency): \_\_\_\_\_  
 \_\_\_\_\_  
 Known medical diagnosis: (if seizures, describe type and frequency): \_\_\_\_\_

Currently under treatment for: \_\_\_\_\_  
 Child referred for further treatment to: \_\_\_\_\_ No further treatment needed \_\_\_\_\_

**LAB TESTS:** Hgb / Hct (within one year) \_\_\_\_\_ Date \_\_\_\_\_ Iron Supplement? \_\_\_\_\_ PPD \_\_\_\_\_ Date \_\_\_\_\_  
 Sickle Cell Screening Results: \_\_\_\_\_ Date \_\_\_\_\_ Lead Screen Results: \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL EXAMINATION:** Height \_\_\_\_\_ in. Weight \_\_\_\_\_ lb. Blood Pressure \_\_\_\_\_ Head Circ. \_\_\_\_\_  
 Visual Acuity: R \_\_\_\_\_ / \_\_\_\_\_ L \_\_\_\_\_ / \_\_\_\_\_ OU \_\_\_\_\_ / \_\_\_\_\_ Hearing: R \_\_\_\_\_ db L \_\_\_\_\_

SYSTEM REVIEWED	NORMAL FOR AGE	ABNORMAL	NOT EVALUATED	COMMENTS - MAY USE BACK OF FORM IF N
Head				
Nose, mouth & throat				
Eyes				
Ears				
Heart				
Lungs				
Abdomen (including hernia)				
Skin				
Genitalia				
Bones, joints, muscles				
Neurological				

This child has had the immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school or has had the immunizat  
 the State Department of Health for infants and toddlers, or is to be exempt from the requirements for medical reasons. Based upon the med  
 physical condition at the time of this examination, this child is free from apparent communicable diseases and is in suitable condition to receive c

Physician's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_