TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

Mailing: P.O Box 25500, Juneau, AK 99802·Physical 9095 Glacier Highway • Juneau AK 99801
Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

PHYSCIAL EXAM: 3 TO 5 YEARS

(Head Start requires complete annual "Well Child" physical exam (EPSDT) documentation of All screenings as necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign, date, and provide a copy to parent/guardian and **FAX a copy to Tlingit & Haida Head Start @ 1.877.389.7796).**

Child's name:_____ Date of birth: _____Exam date:_____

Assessment Codes:	√ - Normal	**Height: (%)**	**Weight: (%)**	**Blood Pressure:**
O – Observe/ watch	**U** – Under			
R – Referred	**Z**- Unable to			

Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested
General Appearance				Eyes			
Posture, Gait				Ears			
Speech				Genitalia			
Head/Neck				Muscular Coordination			
Skin				Motor Ability			
Mouth/Teeth				Self-help/Social Skills			
Heart				Communication Skills			
Lungs				Cognitive Skills			
Abdomen (Hernia)				**Allergies (List):**			

LABORATORY

Hematocrit/Hemoglobin	Date:	Results:	**Immunizations Given at this visit:**			**Current: ___Yes____ No**	
Lead	Date:	Results:	❑ Polio	DTP/DTaP	MMR	❑ HepB	❑ HIB
Sickle Cell	Date:	Results:	❑ Other (List):				
Urinalysis	Date:	Results:	Next Shots Due/Date:				
Tuberculin Skin Test	Type:	Date of Test:	Date Read:	Results: ❑ Negative ❑ Positive	Rx Date:	Chest X-ray Date:	Results: ❑ Negative ❑ Positive
Risk Assessment:							

VISION	**Date:**	**HEARING**	**Date:**			
Acuity - Right Eye:	/	Frequency	1000	2000	3000	4000
Acuity - Left Eye:	/	Right Ear	dB	dB	dB	dB
Strabismus:		Left Ear	dB	dB	dB	dB
Screening Tool/Type:		**Screening Tool/Type:**				

Findings, Treatments & Recommended / Referral Follow-up:

List Medications:

Clinic name:_____Community:_____Insurance type:_____

Physician, PA, FNP, etc. Name /print: _____ Telephone: _____

Provider's Signature: _____**Date:** _____

_____ _____

Parent /Legal Guardian Signature Authorizing Release Date: