PLEASE FILL OUT FORM COMPLETELY AND MAIL OR FAX TO:

Pocatello Head Start 330 Oakwood Dr., Pocatello, ID 83204 Fax (208) 232-4906

CHILD'S NAME:_____________________________________SEX______BIRTH DATE:_________________

ACTUAL DATE OF EXAM_____________________________ Doctor's Phone # ________________________

PLEASE PRINT DOCTOR'S NAME____(Required)

	Normal	Abnormal	Comments
General Appearance			
Posture			
Speech			
Head			
Skin			
Eyes			
Ears			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological			
Coordination			
Glands			
Blood Pressure			
Hemoglobin/Hematocrit			

Is this child current for age on required immunizations? YES_____ NO_____

Were any vaccinations given today? (Please list) ____________________________________

Is this child on any Medication? YES_____ NO_____ Any Allergies? YES_____ NO_____

Additional Comments:

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***Must have the Doctor Signature and Actual Date of Exam per Federal Guidelines.**

Signature ____ **Date**___________________________

PLEASE MAIL OR FAX
WITHIN 7 DAYS
OF EXAM

White copy: Send to Head Start

Yellow copy: Retain for medical records