NORTHERN TIER COMMUNITY ACTION CORP.

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DAVID GREENE
EXECUTIVE DIRECTOR

Child Health Program / Physical Examination

Attention Health Care Provider –This form must be complete to ensure compliance with Head Start Regulations.

Child's Name: _____ Sex: _____ Date of Birth: _____

Head Start Center: _____

Height in Inches: _____ Weight: _____ Blood Pressure: _____ Vision: _____ Hearing: _____

Please Indicate Each Assessment

General Appearance	Normal _____	Abnormal _____
Eyes	Normal _____	Abnormal _____
Ears	Normal _____	Abnormal _____
Nose, Throat, Pharynx	Normal _____	Abnormal _____
Teeth	Normal _____	Abnormal _____
Heart	Normal _____	Abnormal _____
Lungs	Normal _____	Abnormal _____
Bones, Joints, Muscles	Normal _____	Abnormal _____

ALLERGIES: _____

Developmental Status (speech, gross motor, fine motor, cognitive): _____

_____

General Assessment of Child's Health: _____

Mental Health Issues:_____

Please note most *recent* results:
Results must be written or typed, N/A is **NOT an accepted result**

Lead Testing _____
Hemoglobin _____

Is This the Child's Medical Home? Yes No

Is Child Currently under Dentist's Care? Yes No

Abnormal Findings/Diagnosis: _____

_____ _____ _____
Physician's Signature Date Telephone

***** Please attach child's current Immunization Record *****

Revised 2/2019