YVEDDI
YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.

Head Start

Physical Examination Form

Revised Date: 6/19/2023

Child's Name:_____ DOB:_____ Date of Examination:_____

Child's Address:_____

Parent's/Guardian's Name:_____ Phone Number:_____

Blood Lead Test Date:_____ Result:_____

Height:_____inches Weight:_____pounds BMI:_____

Vision: Left Pass___ Fail___ Right Pass___ Fail___ Both Eyes Pass___ Fail___ Testing Modality (Snellen chart, Autorefraction, Transillumination test, etc.)_____

Hearing: Left Pass___ Fail___ Right Pass___ Fail___ Both Ears Pass___ Fail___ Testing Modality (Wisper test, OAE, Pure Tone Audiometry, etc.)_____

Physical Examination: *To be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering state), a certified nurse practitioner, or a public health nurse meeting the standards for the EPSDT program.*

Examination Results	Normal	Abnormal (describe findings)	Not Tested	Examination Results	Normal	Abnormal (describe findings)	Not Tested
General Appearance				Teeth, Mouth			
Posture, Gait				Heart			
Speech				Lungs			
Head				Abdomen			
Skin				Musculoskeletal			
Eyes				Neurological			
Ears				Developmental			
Nose, Pharynx				Psychosocial			

List any allergies, chronic conditions or special accommodations: _____

_____

_____

List any medications required at school (include medication name and dosage): _____

_____

Is the child cleared to enter Head Start? _____Yes ____No

Provider Name (please print): _____ Signature:_____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____