Doña Ana County Head Start **FEDERAL REQUIREMENT #1304.20** **Physical Exam Form**

Parent/Guardian fill this section — Padre/Guardián llene esta sección

Child's Name/ Nombre del Niño: _____ **Sex / Sexo:** □ **M** □ **F**

Date of Birth/ Fecha de nacimiento: **Center:** □ **AM** □**PM**

How do you pay for health care? Check all that apply:
¿Cómo paga por el cuidado de la salud? Favor de marcar todo lo que aplique:

□ Medicaid □ Private Insurance / Aseguranza privada □ CHIPS
□ No Insurance / Sin Aseguranza □ Sliding Scale / Escala de cálculo

Permission for Release of Information / Permiso de Proveer Información
I give permission for the healthcare provider to release the requested information to DACHS Head Start.
Yo doy permiso a mi doctor para dar la siguiente información a DACHS Head Start.

Parent or Guardian Signature / Firma: **Date / Fecha:**

Health Care Providers – please complete sections below

Blood Lead Level: **Collected Date:**

Hgb / HCT: **Collected Date:**

Blood Pressure: **Date:**

Vision: ☐ Pass ☐ Fail ☐ Refer **Hearing:**☐Pass ☐ Fail ☐ Refer

BMI: <5% WNL >95%

Is the child receiving treatment for:

☐ **Anemia** ☐ **Asthma** ☐ **Overweight** ☐ **High Lead Levels**

☐ **Diabetes** ☐ **Food Allergy** ☐ **Vision Difficulties** ☐ **Hearing Problems**

☐ **Other**: please indicate severity and treatment._____

Does the child need a follow-up appointment? ☐Yes ☐ No **Date of follow-up?**_____/_____ /_____

If so, please indicate:

Any Concerns? ☐ Yes ☐ No

Is this child up-to-date on the EPSDT schedule? ☐ Yes ☐ No

Is the Medicaid periodicity schedule being followed? ☐ Yes ☐ No

Immunization Status: ☐ Up-to-date ☐ Catch-up-schedule **Patient Needs:**

Physical Examination Completed by: (please print name) _____

Exam Date:

Phone: **Fax:** **Signature:**

Please Submit to:
Doña Ana County Head Start / Health Specialist
Address: 2540 El Paseo, Suite B, Las Cruces, NM
Phone: 575-647-8733 Ext. 116 Fax: 575-647-8734

Health/Phy_Exam/4.12 3.17

ENTERED INTO CHILDPLUS

BY:_____

DATE:_____