Shippensburg Head Start/ Pre-K Program
Shippensburg University
1871 Old Main Drive, Box 58
Shippensburg, PA 17257-2299
Phone 717-477-1626, Fax 717-477-4097
Email: HEADSTART@ship.edu,
www.SHIP.EDU/HEADSTART

# Physical Exam

**Child's Name: _____ Date of Exam: _____**

| | Normal | Abnormal | | Normal | Abnormal | |
|---|---|---|---|---|---|---|
| **General Nutrition** | ☐ | ☐ | **Abdomen** | ☐ | ☐ | |
| **Skin** | ☐ | ☐ | **Genitalia (Male)** | ☐ | ☐ | |
| **Eyes** | ☐ | ☐ | **Neuro-Muscular System** | ☐ | ☐ | |
| **Nose & Throat** | ☐ | ☐ | **Skeletal** | ☐ | ☐ | |
| **Teeth & Gingiva** | ☐ | ☐ | **Emotional Status** | ☐ | ☐ | |
| **Glands** | ☐ | ☐ | **Ears** | ☐ | ☐ | |
| **Heart** | ☐ | ☐ | **Vision** | ☐ | ☐ | **R-20/__ L-20/__ Both 20__** |
| **Pulse** | ☐ | ☐ | **Hearing** | ☐ | ☐ | **Passed- Unable- Refer(circle)** |
| **Lungs** | ☐ | ☐ | **Speech/Language** | ☐ | ☐ | |

**Height: _____ inches Weight: _____ pounds Blood Pressure: _____/_____**

**LEAD TEST RESULTS ARE REQUIRED FOR HEAD START PROGRAM, NOT PRE-K, EVEN IF THE TEST WAS NOT COMPLETED AT LAST VISIT PLEASE PROVIDE LATEST TEST RESULTS.**

**Lead Test: _____ Date _____ Results**

**Hematocrit/Hemoglobin: _____ Date _____ Results**

**Explain Findings & Note Recommendations: _____**

**Immunizations Received Today: _____**

**Any Known Allergies? _____**

**Does This Child Have Any Special Needs That Require A Special Care Plan? _____ Yes _____ No**

**** If yes, please complete attached Special Care Plan. A Care Plan is needed for all children with Asthma, any Heart Conditions, Allergies, ETC.**

*Physician Office's Exam Summary is also acceptable in place of this form as long as all information is included.*

**Name Of Physician & Address: _____**

**(please print)** _____

_____

**Physician's Signature: _____** **Rev. 5/15**