Dona Ana County Head Start FEDERAL REQUIREMENT #1302.42 Physical Exam Form

Parent/Guardian fill this section Padre/Guardian Ilene esta seccion

Child's Name/ Nombre del Nifio: _____ Sex/ Sexo: ☐M ☐F

Date of Birth/ Fecha de nacimiento: Center: ☐AM ☐PM

How do you pay for health care? Check all that apply:
;.Como 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 calculo

Permission for Release of Information / Permiso de Proveer Informacion
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 informacion 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% Height: Weight:

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: D Up-to-date D Catch-up-schedule Patient Needs:

Physical Examination Completed by: (please print name) _____
Exam Date:

Phone: Fax: Si2nature:

College of Education
Dona Ana County Head Start, MSC 3R
P.O. Box 30001
Las Cruces, NM 88003-8001
Phone: 575 646-8910 or
Health Specialist: 575- 646-8902

Fax: 575 646-3047

ENTERED INTO CHILDPLUS
BY:- - - - - - - - -
DATE:- - - - - - - -