AVOYELLES CHILD DEVELOPMENT SERVICES, INC.
HEAD START PHYSICAL EXAMINATION FORM

Note to provider: Please provide **ALL** the information below based on the **most recent well child exam**.

Child's Name: _____ Date of Birth: _____

Date of Physical Exam: _____

Is this child up to date on all well child care? ___YES ___NO

If NO, please explain what is needed: _____

MEASUREMENTS - HEIGHT &WEIGHT:

Height: _____inches **Weight: _____ pounds**

HEARING SCREENING:

O **Pass** O **Fail** If failed, please describe follow-up recommendations: _____

VISION SCREENING:

O **Pass** O **Fail** If failed, please describe follow-up recommendations: _____

BLOOD PRESSURE:

Systolic: _____ **Diastolic: _____** Comments: _____

BLOOD COUNT:

Hemoglobin: _____ or Hematocrit: _____ Comments: _____

LEAD SCREEN:

Test Score: _____ Comments: _____

CURRENT MEDICATIONS (Please List if Any): _____

CURRENT ALLERGIES (Please List if Any):_____

Recommendations for Follow-Up, Further Treatment, or Comments: _____

_____

MEDICAL PROVIDER: _____

Address: _____ **Phone #:**_____

Signature: _____ **Date:** _____

AVOYELLES CHILD DEVELOPMENT SERVICES, INC.
HEAD START DENTAL EXAM FORM

Child's Name: _____ Date of Birth: _____

Date of Dental Exam and/or Treatment: _____

DENTAL SERVICES PROVIDED (Check/Complete All that Apply):

Preventative Services Provided:

- ☐ Bitewing Films
- ☐ Cleaning
- ☐ Fluoride Supplement
- ☐ Sealants
- ☐ Oral Hygiene Instruction
- ☐ Other (Please Explain):_____

Treatment Needed (Specify):_____

Treatment Received: _____

Date Scheduled for Next Appointment: _____

Recommendations for Follow-Up, Further Treatment, or Comments: _____

_____

DENTAL PROVIDER: _____

Address: _____ Phone #:_____

Signature: _____ Date: _____