



TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

Mailing: 9097 Glacier Hwy, Juneau, AK 99801 • Physical 9095 Glacier Highway • Juneau AK 99801
 Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

PHYSICAL EXAM: 3 TO 5 YEARS

(Head Start requires complete annual "Well Child" physical exam (EPSDT) documentation of All screenings as necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign, date, and provide a copy to parent/guardian and **FAX a copy to Tlingit & Haida Head Start @ 1.877.389.7796**).

Child's name: _____ Date of birth: _____ Exam date: _____

Assessment Codes:	√ - Normal	Height: (%)	Weight: (%)	Blood Pressure:			
O - Observe/ watch	U - Under			Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested
R - Referred	Z- Unable to						
Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for Age	Abnormal (Describe Findings)	Not Tested
General Appearance				Eyes			
Posture, Gait				Ears			
Speech				Genitalia			
Head/Neck				Muscular Coordination			
Skin				Motor Ability			
Mouth/Teeth				Self-help/Social Skills			
Heart				Communication Skills			
Lungs				Cognitive Skills			
Abdomen (Hernia)				Allergies (List):			

LABORATORY

Hematocrit/Hemoglobin	Date:	Results:	Immunizations Given at this visit: Current: <u> </u> Yes <u> </u> No				
Lead	Date:	Results:	<input type="checkbox"/> Polio	DTP/DTaP	MMR	<input type="checkbox"/> HepB	<input type="checkbox"/> HIB
Sickle Cell	Date:	Results:	<input type="checkbox"/> Other (List):				
Urinalysis	Date:	Results:	Next Shots Due/Date:				
Tuberculin Skin Test	Type:	Date of Test:	Date Read:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Rx Date:	Chest X-ray Date:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Risk Assessment:							

VISION	Date:	HEARING	Date:			
Acuity - Right Eye:	/	Frequency	1000	2000	3000	4000
Acuity - Left Eye:	/	Right Ear	dB	dB	dB	dB
Strabismus:		Left Ear	dB	dB	dB	dB
Screening Tool/Type:		Screening Tool/Type:				

Findings, Treatments & Recommended / Referral Follow-up:

List Medications:

Clinic name: _____ Community: _____ Insurance type: _____

Physician, PA, FNP, etc. Name /print: _____ Telephone: _____

Provider's Signature: _____ **Date:** _____

Parent /Legal Guardian Signature Authorizing Release _____ **Date:** _____