Head Start Child Physical Exam

Three Rivers Community Action, Inc.
1414 North Star Drive, Zumbrota, MN 55992
Phone: 507-951-9954 Fax: 507-933-4481

Child's Name _____ Date of Birth _____
Parent's Name _____ Sex _____
Name of Clinic _____
Physician's Signature _____
Printed Name of Health Care Provider _____
Date of Exam _____

Please note: these items are Federally mandated for children in Head Start

Height ____ ft. ____ in. Weight ____ lbs. Visual Activity R ____ L ____
Blood Pressure _____ HTC/HGB _____ Hearing R ____ L ____
Lead _____

Area	N/AB	Comments	Area	N/AB	Comments
Head			Neurological		
Face			Spine		
Mouth			Cardiovascular		
Neck			Abdomen		
Eyes			Genitalia		
Ears			Extremities		
Nose			Joints		
Throat			Muscle Tone		
Chest			Skin		

1. Does child have any allergies? (food, insect, other) No Yes
   If yes, list type and give recommendations: _____
2. List any medications child is taking: _____
3. Is child developing appropriately for his/her age? No Yes
   If no, what modifications are needed? _____
4. Is a special diet necessary? No Yes
   If yes, please identify restrictions: _____
5. Is there a condition which may result in an emergency? No Yes
   If yes, please specify: _____
6. Please indicate any notable health problems, restrictions, or modifications:
   _____

IF child has ASTHMA, please fill out the back of this form with plan.

Please attach a current copy of child's immunization record
List any Immunizations given today:

Head Start Asthma Quick Relief & Emergency Plan

***Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.*

Severe cough	Turning blue	Blueness of fingernails and lips
Chest tightness	Rapid, labored breathing	Difficulty walking from breathing
Wheezing	Sucking in of the chest wall	Difficult talking from breathing
Shortness of breath	Shallow, rapid breathing	Decreased or loss of consciousness

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications As Listed Below

Quick Relief Medications	Dose/Frequency	When to Administer

2. Contact Parents if

3. Call 911 to activate EMS if the student has ANY of the following:

- Lips or fingernails blue or gray
- Student is too short of breath oto walk, talk, or eat normally
- No relief from medication within 15-20 minutes with any of the following:
  - Chest and neck pulling in with breathing
  - Childis hunching over
  - Child is struggling to breathe

Physician Signature **Date**

Parent Consent for Management of Asthma at Head Start

I, the parent or guardian of the above named student, request that this Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the teacher of any changes in the student's health status.
3. Notify the center and complete new consent for changes in orders from the student's health care provider.
4. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Legal Guardian Signature **Date**