Fresno EOC
Head Start
0 to 5

Early Care
&
Education

PHYSICIAN'S REPORT
(Preadmission Health Eval)

CB/HB SITE PHONE: _____ **CB/HB SITE FAX:** _____

CB STAFF/HBE: _____

CHILD: _____ **DOB:** _____

PARENT NAME: _____

Dear Physician:

Please provide a detailed report on above-names child using the form below. I hereby authorize release of medical information contained in this report to the above-names Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OT CHILD'S AUTHROIZED REPRESENTATIVE) (TODAY'S DATE)

1. Allergies: _____ **Medicine:** _____ **Food:** _____ **Insect Stings:** _____

2.	**Dental:**	Date	Finding
3.	**Developmental:**	Date	Finding
4.	**Language Speech:**	Date	Finding
5.	**Physical Examination:**	Date	Finding
6.	**TB Risk Assessment:**	Date of Assessment	☐ Risk factors not present (TB NOT NEEDED)
7.	**Intradermal TBST (PPD):**	Date Given	Date Read / Result
8.	**Blood Lead Level (Any age):**	Date	Micrograms/dl ☐ No Risk (for lead exposure)
9.	**Hemoglobin/Hematocrit:**	Date	GM% ☐ No Risk (for anemia)
10.	**Vision Screening:**	Date	**R** **L** Finding
11.	**Hearing Screening:**	Date	**R** **L** Finding
12.	**Blood Pressure:**	Date	Finding
13.	**Growth:**		HT. WT.
14.	**Immunization Given:**	Date	

Other Findings: (include) behavioral _____

Comments: _____

Physician: _____ Date of Physical Exam: _____
Address: _____ Date this Form Completed: _____
Telephone: _____ Signature: _____

Fresno Economic Opportunities Commission

Oliver Baines Board Chair
Emilia Reyes Chief Executive Officer

FRESNO EOC HEAD START 0 TO 5
HEALTH SERVICES PROGRAM SERVICE AREA

Dear Parent/Guardian:

Head Start requires a **complete CHDP Equivalent Health Exam**. Documentation of all screenings are necessary. Written proof of a current annual physical is due within 30 days of enrollment.

IT MUST include:

1. "Head to Toe" Examination
2. Vision Screening
3. Hearing Screening
4. Blood Pressure
5. Height and Weight
6. Hemoglobin/HCT
7. Blood Lead Level from any year
8. TB risk assessment or TB test/ Chest X-ray for positive TBST

Child may be excluded at 30 days if the physical is not received or is incomplete.

Please provide this information to the health provider that you have chosen for your child's examination. This list follows the printed physical examination form given to you by Head Start.

*If your child has a previous history of a "Positive" tuberculin skin test, a chest x-ray report is required.

(559) 263-1000 Fresno

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FRESNO EOC HEAD START 0 TO 5
ÁREA DE SERVICIO DEL PROGRAMA DE SERVICIOS DE SALUD

Estimado(a) Padre/Madre/Tutor:

Head Start requiere un **Examen de Salud Equivalente al CHDP completo**. Se requiere documentación para todos los exámenes. Se debe entregar una prueba por escrito del físico anual actual dentro de los 30 días de inscripción.

Debe incluir:

1. Examen de "Pies a Cabeza"
2. Examen de la Vista
3. Examen del Oído
4. Presión Arterial
5. Peso y Estatura
6. Hemoglobina/HCT
7. Nivel de Plomo en la Sangre de cualquier año
8. Evaluación de riesgo de Tuberculosis o prueba de Tuberculosis/Radiografía de pecho si la prueba de piel fue positiva.

El/La niño(a) puede ser excluido(a) si a los 30 días no se recibe el físico o si esta incompleto.

Por favor proporcione esta información al proveedor de salud que haya elegido para el examen de su hijo(a). Esta lista continúa con el formulario del examen físico que se le proporciono por Head Start.

* Si su hijo(a) ha tenido historial previo de una prueba de piel de la tuberculina "Positiva," se requiere una radiografía de pecho.

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