HEAD START CHILD PHYSICAL EXAM

Three Rivers Head Start
1414 North Star Drive Zumbrota, MN 55992
(507) 322-3103 – Fax (507) 933-4481

Child's Name _____ Date of Birth _____
Parent's Name _____ Sex _____
Name of Clinic _____
Physician's Signature _____
Printed Name of Health Provider _____
DATE OF EXAM _____

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

Heights _____ft. _____in. Weight _____lbs. Visual Acuity R _____L _____

Blood Pressure _____/_____HCT/HGB _____ Hearing R_____ L_____

Lead _____

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

1. Does child have any allergies? (food, insect, other) No_____Yes_____ If yes, circle 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___Please identify restrictions:
5. Is there a condition which may result in an emergency? No__Yes___Please specify:
6. Please indicate any notable health problems, restrictions, or recommendations:

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:

Headstart 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	Shortness of Breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & lips	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
1.		
2.		

2. Contact Parents if_____

3. Call __911_____ to activate EMS if the student has ANY of the following:

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

Physician signature:_____**Date:**_____

Parent Consent for Management of Asthma at Headstart

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 _____

Reviewed by Health Consultant _____ Date _____