Bucks County
Intermediate Unit

EARLY CHILDHOOD PROGRAMS
CHILD HEALTH ASSESSMENT

Child's Full Name:		Parent/Guardian Name:
Child's Date of Birth:	Parent/Guardian Phone #:	Date of most recent well-child exam:

Please complete all sections of this form to comply with Head Start and Pre K Counts Regulations

Length/Height	Weight	Head Circumference (infants only)	Blood Pressure
_____inches	_____lbs	_____inches	_____/_____

Physical Examination	□ = Normal	If Abnormal - Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

Record Immunizations Below or Attach a Separate Sheet

Immunizations	Date	Date	Date	Date	Date	Comments
DTa/DTP/Td						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Pneumococcal						
Other						

Screening Tests listed are *required* by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates and values even if the screening was completed during a previous exam

Screening Tests	Date Test Done	Numerical Results, if applicable
Lead*		
Anemia (HGB or HCT)*		
Hearing*		
Vision*		

Does the child have any special needs or require any medications during the school day? Please list.

Medical Care Provider:	Signature of Physician or CPNP:
Address:	

Phone Number:	License Number:	Date Form Signed: