



**Cincinnati-Hamilton County
Community Action Agency**
We help make things happen



Physical Examination/ Assessment Form

Please return exam results to:
Cincinnati Public Schools
2120 Vine Street, Cincinnati, Ohio 45202
Telephone: 513-363-6580 Fax: 513-363-6585

PARENTS: Head Start requires a physical exam, please return or fax this form when completed.

Child's Name _____ Sex: M F D.O.B. _____
Parent/Guardian's Name _____ Phone _____
Address _____ Zip _____ Center _____

Required Screenings:

Lead Test Results: _____ Date Completed: _____ HCT/HGB: _____ Date Completed: _____
Blood Pressure: ____/____ Height: _____ Weight: _____ Vision: P / F Hearing: P / F

General Exam:

Evaluation	Normal	Abnormal	Evaluation	Normal	Abnormal
Skin			Abdomen & Groin		
Posture, Gait			Genitalia & Urinary		
Speech, Communication			Bones, Joints		
Head			Neurological		
Eyes			Gross & Fine Motor		
Ears			Muscles		
Nose			Cognitive		
Mouth, Teeth, etc.			Self Help		
Heart & Circulatory			Social Skills		
Chest & Lungs			Glands Thyroid, Lymph		
Weight			Other:		

Allergies: _____

Chronic Conditions: _____ Immunizations on Schedule? Yes No
(Please attach copy of immunizations)

ABNORMAL FINDINGS/DIAGNOSIS	PLAN OF ACTION	RECOMMENDED FOLLOW-UP AND TIME FRAME

This child has been examined and is in suitable condition for participation in group care. The child has had the age appropriate immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school; or has had the immunization required by Ohio Department of Health for infant and toddlers; or is to be exempted from immunizations for the following reasons:

Practice/Clinic Name & Address: _____
Phone Number: _____ Fax Number: _____ Exam Date: _____
Physician (please print): _____ Physician Signature: _____

Verlaine Dotson
Grantee Head Start Director