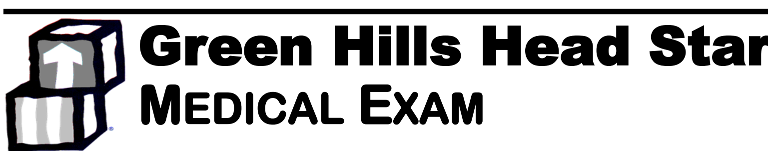

Green Hills Head Start MEDICAL EXAM 2023-2024

Exam Date: ____________

Child's Name:	Parent's Name:
Birthdate:	Address:
Head Start Location:	Phone:

Well Child Visit (Circle One): 2wks 1mo 2mo 4mo 6mo 9mo 12mo 15mo 18mo 24mo 36mo 3y/o 4y/o 5y/o

YES	NO	Please answer the following questions.
		✸ **Child is ABLE to participate in Child Day Care. (This must be marked)**
		Child appears to be free from contagious or communicable diseases and is receiving health care.
		Child is in the process of receiving recommended immunizations.
		Child has special health care needs. If yes, list special provisions needed for the child to participate in Day Care on the back of this form.
		Does the child have ☐Allergies, ☐Asthma, or ☐Seizure Disorders? If yes, list Allergies/Medications/Treatments on back of this form.
		Does the child need an iron supplement? If yes, include prescription.

REQUIRED INFORMATION

Height _________ **Weight** _________	**HCT/HGB Results:**
Blood Pressure:	**Lead Testing Results:**

PHYSICAL	Normal	Abnormal	Not Evaluated	Comments	PHYSICAL	Normal	Abnormal	Not Evaluated	Comments
General Appearance					Lungs				
Posture, Gait					Abdomen				
Speech					Genitalia				
Head					Bones/Joints/Muscles				
Skin					Neurological/Social				
Eyes: External Aspects					Gross Motor				
Optical Funduscopic					Fine Motor				
Cover Test					Communicative Skills				
Ears: External/Canals					Cognitive				
Tympanic Membrane					Self-Help Skills				
Nose/Mouth/Pharynx					Social Skills				
Teeth					Glands/Lymphatic/Thyroid				
Heart					Muscular				

READ BEFORE BILLING

Head Start will pay ONLY if the child is NOT ELIGIBLE for insurance or Medicaid. A current denial of Medicaid from FSD must be on file before Head Start funds can be authorized for payment. Payment fees for services are recommended by the Health Advisory Board. **Please contact Head Start for prior approval. If approved, Head Start will pay up to $45 for physicals, $5 for HCT's, and $14.95 for lead screenings.**

Bill Medicaid? NO YES Medicaid Number: ____________________ Payment Authorized by: ______________________________

Mail to: Green Hills Head Start, PO Box 177, Trenton, MO 64683 (660)359-2214 Fax: (660)359-5787

► Doctor's/CFNP's Signature: ____ **Date:** ____________________

PRINT Doctor's/Supervising Doctor's Name ____

Doctor's Address: ____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

INDIVIDUAL PLAN FOR SPECIALIZED CARE

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE	DATE
✕	

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