



Green Hills Head Start MEDICAL EXAMINATION

2022-2023



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

CHILD INFORMATION

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

IMMUNIZATIONS

* Has this child ever had **CHICKEN POX**? NO YES When? *

Any recent immunizations given? NO YES (Give date)

DTP/DT Polio Hib MMR Hep A Hep B Varicella PCV Other

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 Funduscopy					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				

REQUIRED INFORMATION

Hematocrit/Hemoglobin Results:	Does the child have Allergies ____, Asthma ____, or Seizure Disorders ____?
Lead Testing Results:	* List Allergies/Medications/Treatments on back of this form.
Blood Pressure:	Does he/she need an iron supplement? NO YES (include prescription)
Height _____ Weight _____	Does he/she require any specialized care? NO YES _____

LIST ANY FINDINGS/DIAGNOSIS/TREATMENT PLANS...

I have examined the above named child and verify that this child's medical history and current state of health

IS IS NOT

satisfactory for participation in a day care program.

► Doctor's/CFNP's Signature: _____ Date: _____

PRINT Doctor's/Supervising Doctor's Name _____

Doctor's Address: _____