Green Hills Head Start
MEDICAL EXAMINATION

2025-2026

Exam Date: _____

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:

Well Child Visit (circle one): 1mo 2mo 4mo 6mo 9mo 12mo 15mo 18mo 24mo 3yr 4yr 5yr

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
General Appearance				
Posture, Gait				
Speech				
Head				
Skin				
Eyes: External Aspects				
Optical Funduscopic				
Cover Test				
Ears: External/Canals				
Tympanic Membrane				
Nose/Mouth/Pharynx				
Teeth				
Heart				

PHYSICAL	Normal	Abnormal	Not Evaluated	Comments
Lungs				
Abdomen				
Genitalia				
Bones/Joints/Muscles				
Neurological/Social				
Gross Motor				
Fine Motor				
Communicative Skills				
Cognitive				
Self-Help Skills				
Social Skills				
Glands/Lymphatic/Thyroid				
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…

Please check the appropriate box (Required)

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 _____

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
X	

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY.