



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?

Any recent immunizations given? NO YES (Give date)

NO YES When?

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 Funduscopy				
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

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.