OFFICE USE ONLY: CENTER:

Community Action Partnership-Head Start (Birth to 5) Program

450 North Syndicate Street, Suite 5, St. Paul, MN 55104
www.caprw.org/Telephone: 651-603-5854/Fax: 651-603-5851

Child & Teen Check-Up Exam

Name: _____ DOB: _____ Gender: ☐ M ☐ F

Is child up to date with C&TC including all required tests: ☐ Yes ☐ No
Are Immunization up-to-date (*Please attach a copy*): ☐ Yes ☐ No

Height: _____ in. Weight: _____ lbs. ☐ No Concern ☐ Concern

Blood Pressure: _____/_____ ☐ No Concern ☐ Concern

Vision Status: ☐ No Concern ☐ Concern ☐ Unable ☐ Refer
R 20/ _____ L 20/_____ Corrected: ☐ Yes ☐ No

Hearing Status: ☐ No Concern ☐ Concern ☐ Unable ☐ Refer

	500 (25)	1000 (20)	2000 (20)	4000 (20)
Right				
Left				

**Required by HS-Previous dates acceptable*

*Lab	Date	Results	Comments
*Hemoglobin			
*Blood Lead Level			

Area	N	AB	Comments	Area	N	AB	Comments
General Appearance				Lungs			
Head				Abdomen			
Face				Genitourinary			
Eyes				Musculoskeletal			
Ears				Spine			
Mouth-Teeth				Extremities			
Throat				Skin			
Nose				Neurological			
Neck				Nutritional Status			
Cardiovascular				Emotional Status			
Chest				Speech			

Allergies: _____
Routine Medications: _____
Is child developing appropriately for his/her age? ☐ No ☐ Yes, please specify: _____
Is a special diet necessary? ☐ No ☐ Yes, please identify restrictions: _____
Is there a condition which may result in an emergency? ☐ No ☐ Yes, please specify: _____
Is there a condition that may interfere with learning? ☐ No ☐ Yes, please specify: _____
Please indicate any present health conditions: _____
Any restrictions or recommendations**:** _____

***Physical Exam Date: _____**
Signature of Health Care Provider: _____ Date Signed: _____

Print Name: _____
Clinic Name: _____
Address: _____ Phone: _____ Fax: _____