Holy Cross Head Start Inc.
150 Maryland Street
Buffalo, New York 14201
Telephone: (716) 852-8373 Fax: (716) 854-7046

Head Start Physical Cover Letter

Date_____

Dear Health Care Provider,

This family is in the process of enrolling their child(ren) in the Holy Cross Head Start Program. All child(ren) must receive a complete annual physical examination with age appropriate screenings and assessments per American Academy of Pediatrics guidelines.

It is important that child(ren) receive the following during their well child visit with you:

A. Immunizations (please record on physical or attach a copy)
B. Blood work required
    1. Lead
    2. Hemoglobin/Hematocrit
    3. Sickle Cell/Hemoglobin Electrophoresis Screen
C. TB Risk Assessment or Mantoux PPD
D. Other recommended tests/screenings
    1. Height and Weight
    2. Blood Pressure
    3. Vision Screening
    4. Hearing Screening

If you have any questions or concerns, please contact the Case Manager at _____

Head Start is a comprehensive, developmental pre-school program that serves income eligible children and their families throughout Erie County.

Sincerely,

Holy Cross Head Start Staff

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Well Child Care Exam

! Information on this form is considered CONFIDENTIAL and must not be disclosed without proper authority!

Child's Name _____ **DOB**___/___/___ **Gender** ☐M ☐F **Date of Exam** ___/___/___
Examiner: Please complete age-appropriate screenings and assessments (current and retrospective) per AAP guidelines. Thank you!

Allergies: ☐NKA ☐YES…Specify

Medications: ☐NO ☐YES…Specify

Acute or Chronic Illnesses: ☐NO ☐YES

Most Recent Occurrence ___/___/___
Details:

Behavioral Concerns:

Head Circ (Infant) _____

BMI _____

Height _____

Weight _____lbs.

Blood Pressure _____mm Hg

Screenings and Risk Assessments

Lead Blood Level: **Tx Needed:** ☐Yes ☐No
Date:_____ **(within one year)** **Level** _____ **mcg/dl**
Result: ☐**Normal** ☐**Abnormal**

Blood Count: **Tx Needed:** ☐Yes ☐No
HCT_____ **% *or* HGB**_____**g/l** **Date:**_____

Sickle Cell Risk Screening: **Tx Needed:** ☐Yes ☐No
☐ **Performed at birth**
☐ **Performed** **Result:** ☐**Normal** ☐**Abnormal…Specify:** ☐ **Disease** ☐ **Trait**

Other: **Tx Needed:** ☐Yes ☐No
Type_____ **Result:** _____

TB Risk Assessment: ☐ **No Risk Factors** ☐ **Risk Factors Present**

A person is considered to be at high risk for TB (tuberculosis infection) if he/she can answer yes to one or more of the following:
* **Contacts with individuals who have infectious tuberculosis**
* **Children who are born outside of the United States**
* **Children determined to have abnormal chest x-rays related to signs of TB**
* **HIV infected children**
* **Children with low immune systems**
* **Children with medical risk factors: Hodgkin's disease, Lymphoma, Diabetes Mellitus Chronic Renal Failure, Malnutrition**
* **Children frequently exposed to adults that are HIV infected, homeless, residents of nursing homes, Migrant farm workers**

Child's Name _____ DOB _____

Hearing: Treatment Needed: ☐Yes ☐No

Tone (age ≥4)	Right	Left
500 dB		
1000 dB		
2000 dB		
4000 dB		
Gross (age<4)	Right	Left
Normal		
Abnormal		

Vision: Treatment Needed: : ☐Yes ☐No

Acuity (age ≥3)	Right	Left	Both
	20/	20/	20/
Gross (age <3)	Right	Left	Both
Normal			
Abnormal			

Strabismus: Treatment Needed: : ☐Yes ☐No

	Right	Left
Normal		
Abnormal		

	Normal	Abnormal	Referred
General Appearance	☐	☐	☐
Posture, Gait	☐	☐	☐
Speech	☐	☐	☐
Head	☐	☐	☐
Skin	☐	☐	☐
Eyes External Aspect	☐	☐	☐
Optic Fundoscopic	☐	☐	☐
Cover Test	☐	☐	☐
Ears External Canal	☐	☐	☐
Nose, Mouth, Pharynx	☐	☐	☐
Teeth / Gums	☐	☐	☐
Heart	☐	☐	☐
Lungs	☐	☐	☐
Abdomen (include hernia)	☐	☐	☐
Genitalia	☐	☐	☐
Bones, Joints, Muscles	☐	☐	☐
Neurological / Social	☐	☐	☐
Gross Motor	☐	☐	☐
Fine Motor	☐	☐	☐
Communication Skills	☐	☐	☐
Cognitive	☐	☐	☐
Self-Help Skills	☐	☐	☐
Social Skills	☐	☐	☐
Glands (Lymphatic / Thyroid)	☐	☐	☐
Muscular Coordination	☐	☐	☐
Other	☐	☐	☐

☐ Immunization Record Attached (If not please complete grid below)

If child is not up to date, please indicate specific follow up dates under "Next Due". OCFS licensing regulation 418.1-11(e)(1) requires Head Start to see evidence of specific follow up appointment dates before it may allow a child to enter program.

Type	1st	2nd	3rd	4th	5th	6th	Next Due	Status	Exemption med / relig	Serologic Immunity Confirm Date
Hepatitis B										
DtaP / DTP										
Hib										
Polio										
MMR										
Varicella										
Pneumococcal										

Based on information gathered during this examination, I find that this child currently appears to be free from contagious or communicable diseases, is receiving health care in accordance with the American Academy of Pediatrics schedule, and is able to attend child day care.

Signature of Examiner _____ **Print Name (or stamp)** _____

Address _____ **Phone#** _____

Completed by *(if different than Examiner)* _____

Date Form Completed *(if different than Date of Exam)* ____/____/____

Revised March 2022