Please return this form to: OFB Head Start,
5 W. State Street, Binghamton, NY 13901 (Fax: 607-723-2101)

HEALTH PROFILE (Physical)

Child's Name: _____ Date of Birth: _____

ALLERGIES: _____ TYPE OF REACTION: _____

SCREENING TESTS	Date	Results
Hematocrit/Hemoglobin: (Follow up if < 11 / < 34%)		
Lead:		
Blood Pressure:		R/ L/
Other:		

Vision Screening: Date: _____ Type: _____ Acuity: _____R _____L Comments: _____	Rescreening
Auditory Screening: Date: _____ Type: _____ Results: _____R _____L Comments: _____	Rescreening

IMMUNIZATION RECORD	1ST	2ND	3RD	4TH	5TH	DT
DPT						
POLIO						
MMR						
HIB						
HEP-B						
VARICELLA						
PNEUMOCOCCAL						

PHYSICAL EXAMINATION		
Head	Eyes	Ears
Nose	Glands (Lymphatic/Thyroid)	Skin
Oral Cavity a. Malocclusion b. Gums c. Tonsils	Chest a. Heart/Lung	Abdomen a. Hernias
Orthopedic a. Posture Functional b. Structural c. Joints d. Extremities	Nervous System a. Speech Defect	Muscular Coordinator
Behavior/Development		Height _____ Weight_____

Medical Conditions: _____

Medications child is currently taking: _____

(Please attach a prescription with administration instructions if medication is to be dispensed during child care hours)

Comments: _____

To the best of my knowledge, this child is free from contagious or communicable disease.

Doctor's Signature _____ Date of Physical Exam _____

Doctor's Name & Address (please print) _____ Phone Number_____