



Lorain County Community Action Agency Head Start Memorandum

Hopkins Locke, Lorain 1050 Reid Ave. (440) 246-0480	Griswold, Elyria 631 Griswold, Rd. (440) 323-1737	Firelands, Oberlin 10643 Vermilion Rd (440) 520-1025	Westwood, Wellington 305 Union St. (440) 647-7440	ELC, Lagrange 12079 Lagrange Rd. (440) 324-3175	Central Plaza / Admin 1949 Broadway (440) 204-3100	South Elyria 107 Oberlin Rd. (440) 220-8301
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HEAD START PHYSICAL FORM

Child's Name: _____ Sex: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____ Zip: _____ Center: _____

ALL OF THE ITEMS MUST BE COMPLETED FOR ADMISSION TO HEAD START

Please review the documentation and complete this record.

Immunization	Date	Date	Date	Date	Date	Is this a Health Check Physical: Yes/No Present Age _____ Years _____ Months _____ Allergies (Ex: Medication Food, Insects) Explain TYPE (see below)
DtaP/DT:						
Polio						
MMR						
HIB					<i>HIB Series 3 complete</i> _____ <i>HIB Series 4 complete</i> _____	
HEP B						
Varicella						
Other						

Test	Date	Results	Test	Date	Results
A. Height (no shoes)			H. Vision (1) Acuity, R/L (2) Strabismus (3) Eye Movements		
B. Weight					
C. Blood Pressure 3-5 yrs.					
D. * Hematocrit or Hemoglobin			I. Other Test (1) Sickle Cell (2) Urinalysis (3) Other		
E. * Lead ***					
F. Hearing					

Please complete the following information:
 Normal Physical Exam _____ Yes _____ No
 Are there any current food allergies or restrictions? _____ Yes _____ No
 If "Yes", then see page 2 (Special Diet) & 3(Request for Medication Administration) may be required _____
 Are there any current medical diagnoses or developmental delays? ___ Yes ___ No
 If yes, please explain: _____
 Is an Individual Health Plan required at school? _____ Yes _____ No
 Is any medical follow-up required? _____ Yes _____ No
 If "Yes" please explain: _____

Based upon the medical history and physical condition at the time of this examination, she/he is free from communicable diseases and had received immunizations required by the state for admission to school under section 3313.671 of the Revised Code. In addition, the child is in suitable condition for enrollment in a daycare center.

Physician's Signature: _____ Date Physical given: _____
 Business Address: _____ Business Phone: _____

* Hematocrit or Hemoglobin & Lead is **REQUIRED** by Head Start **If there are any questions or concerns regarding the requirements of this form, please contact the Health and Nutrition Specialist at rrodriguez@lccaa.net** rev.12/2024 mv/rr