Livingston Educational Service Agency
Head Start and Great School Readiness Programs

Student Health Appraisal

Child's Name________________________________ ____ Sex__________ Date of Birth____________________
Last First Middle

Parent(s)/Guardian(s) Name_ ________ Today's Date____________________

Current Medications______________________________________Reason for Medication____________________

Allergies____

Section I - Vital Signs

Height__________________________ Weight____________________ Blood Pressure Reading______________

ALL COMPONENTS MUST BE COMPLETED TO AVOID EXCLUSION

Section II - Physical Exam

	Normal For Age	Atypical	Under Care
General Appearance			
Skin			
Head/Scalp			
Eyes			
Ears/Nose/Throat			
Chest/Lungs			
Heart			
Abdomen			
Musculo-skeletal			
Neurological			
Genitalia			
Oral Screen (teeth & mouth)			

Section III - Screenings

	Normal For Age	Atypical	Under Care
Speech			
Social Emotional Development			
Vision			
Hearing			
LABORATORY STUDIES	**Result**	**Not At Risk**	**A BOX MUST BE CHECKED FOR EACH TEST**
Hematocrit/Hemoglobin			
Cholesterol			
Sickle Cell			
Tuberculin Test			
Blood Lead			

If atypical on Physical Exam or Screenings, please comment:

Section IV - Other Relevant Health Information

Immunizations given at this visit:____

Conditions that may require emergency care:
____

Health problems which need physical attention or care:____

Should the student's activity be restricted because of any physical defect or illness? Yes No

If yes, please explain:____

__________________________________ ____________________

Examiner's Signature **Date**

____

Examiner's Printed Name

Early Childhood Programs fax number: 517-548-6766

Address:______________________________
____

I give permission for this information and test results to be shared with my child's Head Start Program

Phone:______________________________ Parent Signature____________________Date:__________