Community Action Partnership of Cambria County
516 Main Street
Johnstown, PA 15901
Phone 814.536.9031

Community Action PARTNERSHIP
Helping People. Changing Lives.

Head Start Programs
pennsylvania

FAX: 814.539.4943

Health Status/Services Provided *Must be completed by family physician for enrollment.*

Child's Name ____
Last First Middle Initial

Parent/Guardian ____

Address ____
Street City Zip Code

Birthdate ____/____/____
Month Day Year

Home Phone

In order for this to be a VALID physical, a number value lead result needs to be present.
PLEASE NOTE: CAPCC Head Start requires that all children have a blood lead level at 2 years of age or after. If one was not done at that time, please do one now. EPSDT with lab results will be accepted.

Date of most recent well child exam
____/____/____
Month Day Year

Medication/Food Allergies: ______________________ ☐ None
Current Medications: ______________________ ☐ None
Health History: ______________________ ☐ None

Length/Height
________ IN/CM %ILE ________

Weight
________ LB/KG %ILE ________

Blood Pressure
(Beginning at age 3)
________ / ________

Early Childhood Program Requirements

Physical Exam

	Normal	Indicate Abnormal Result
Head/Ears/Eyes/Throat		
Teeth		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

Screening Tests

	Date Test Done	Result
2 year-old Lead Level	___/___/___	# Result required:
HBG	___/___/___	
Current Vision	___/___/___	
Current Hearing	___/___/___	

Dental History

Date of last exam
____/____/____
Month Day Year

☐ Taking chewable fluoride
☐ Given fluoride prescription
☐ Fluoride supplement not indicated

PLEASE ATTACH IMMUNIZATION RECORD
REQUIRED FOR ENROLLMENT

Examiner's comments

Medical Provider's Signature ______________________ **Date Signed:** __________ **Next Appt.:** ________

Medical Provider's Name & Address (Please Print) ____

03-24-2015 EC Form # H-6 (yellow)