

Return this form to : Siletz Tribal Head Start, PO Box 549, Siletz, OR, 97380.

Siletz Tribal Head Start Health Summary.

This form must be completed and signed by a physician. Please do not defer any tests.

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

Parent/Guardian Name: _____ Phone Number: _____

| Medical Personnel Only | Medical Personnel Only |
|--|---|
| At risk for Iron Deficiency Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes please perform Hct. Or Hgb.</i> | Has child had a Lead Screen at 12 and 24 months <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please perform lead Screen/results</i> |

Date of Exam: _____ Examiner's Name: _____

Height: _____ Weight: _____ Vision: R _____ L _____

Hearing: R _____ L _____ Blood Pressure: _____ Immunizations Needed: _____

When recording results for the following, please enter: **N-normal, A-abnormal, NE-not evaluated.**

General Appearance: _____ Head: _____ Skin: _____ Abdomen: _____ Glands: _____

Nose/Mouth/Pharynx: _____ Heart: _____ Lungs: _____ Muscular Coordination: _____

Bones/Joints/Muscles: _____ Eyes: _____ Ears: _____ Genitalia: _____

1. Does this child's medical history and/or examination indicate any condition that would limit her/his participation in Head Start activities: _____ **NONE YES**, Specify: _____

2. Is any further medical treatment or specific health recommendation necessary for this child? **NONE**
Yes, Specify: _____

Physician Signature: _____

Clinic/Office Address: _____

Telephone: _____