



BROOME COUNTY HEAD START

...a service of Opportunities for Broome Inc.



New Address as of June 1, 2009:
5 W. State Street, Binghamton, NY 13901

Phone: (607) 772-6810

Fax: (607) 723-2101

Dear Doctor:

The following are requirements imposed by different regulatory agencies affecting operation of our program. Please help us to be in compliance by fulfilling these obligations, as shown in bold letters on the attached "Health Profile".

Head Start Federal Regulations require the following:

- Vision Screening
- Hearing Screening
- Height and Weight
- Hemoglobin or Hematocrit
- Blood Pressure
- Lead Screening

American Academy of Pediatrics; Center for Disease Control; and Head Start

5 DPT (5th cannot be given before 4 years of age)

4 Polio

2 MMR

4 HIB* before age of 15 months OR 1 HIB after age of 15 months and before 5 years of age

3 HepB

1 Varicella

Thank you for your cooperation.

Sincerely,

Cynthia Hurlburt
Health Specialist

CH/rs

*This schedule is for children who began immunizations in the first year of life.

Please return this form to: Broome County 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 or 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	1 ST	2 ND	3 RD	4 TH /B1	5 TH /B2	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 and is able to participate in a child care program.

Doctor's Signature _____ Date of Physical Exam _____

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