Regina Coeli Child Development Center

Physical Examination Form

Name: _____ **DOB** _____/_____/_____

Address: _____ **SSN** _____/_____/_____

_____

Position in Head Start: _____

Health History:

Have you ever been treated for the following:

Yes	No		Yes	No	
___	___	head or spinal injury	___	___	asthma
___	___	heart disease	___	___	tuberculosis
___	___	diabetes	___	___	ulcers
___	___	kidney disease	___	___	other

If yes to any of the above, please explain: _____

_____

_____

History of previous illnesses or injuries: _____

_____

_____

Physical Examination:

Height: _____ Weight: _____ Blood Pressure: _____ /_____

TB Skin Test

Date: _____ Positive [ ] Negative [ ]

1. Eyes: Visual Acuity R_____ L _____ Glasses: Yes [ ] No [ ]
2. Ears: Right _____ Left _____
3. Heart: _____
4. Lungs: _____
5. Communicable Diseases: _____
6. Extremities: _____
7. Spine: _____

This individual ____is ____ is not able to perform the duties of the above named position in Head Start.

Comments: _____

_____

_____ _____

Physician Signature *Date*

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