Lorain County Community Action Agency
Head Start Memorandum

Hopkins Locke, Lorain	Griswold, Elyria	Firelands, Oberlin	Westwood, Wellington	Lagrange	Main Office
1050 Reid Avenue	631 Griswold Avenue	10779 Vermilion Rd	305 Union St.	12079 LaGrange Rd	936 Broadway Ave
Phone: (440) 246-0480	Phone: (440) 323-1737	Phone: (440) 984-2417	(440) 647-7440	(440)242-2178	Phone: (440) 245-2009
Fax: (440) 246-0496	Fax: (440) 323-1218	Fax: (440) 984-2422			Fax: (440) 244-0447

HEAD START PHYSICAL FORM

Child's Name:_______________________________________ Sex: ______ DOB: ______________________

Parent/Guardian Name:____ Phone:_________________

Address:____ Zip:________________ Center:______

ALL OF THE ITEMS MUST BE COMPLETED FOR ADMISSION TO HEAD START

Please Review documentation and complete this record.

Immunization	Date	Date	Date	Date	Date
DtaP/DT:					
Polio					
MMR					
HIB					*HIB Series 3 complete___* *HIB Series 4 complete___*
HEP B					
Varicella					
Other					

Is this a Health Check Physical: Yes/No

Present Age ______
Years______
Months______

Allergies (Ex:Medication Food, Insects)
Explain TYPE(see below)

Test	Date	Results	Test	Date	Results
A. Height (no shoes)			H. Vision		
B. Weight			(1) Acuity, R/L		
C. Blood Pressure 3-5 yrs.			(2) Strabismus		
D. * **Hematocrit or Hemoglobin**			(3) Eye Movements		
E. * **Lead *****			I. Other Test		
F. Hearing			(1) Sickle Cell		
G. Head Circumference 0-3 yrs.			(2) Urinalysis		
			(3) Other		

Please complete the following information:

Normal Physical Exam ______ Yes ______ No

Are there any current food allergies or restrictions? ______ Yes ______ No

If "Yes", then see page 2 (Special Diet) & 3(Request for Medication Administration) may be required______

Are there any current medical diagnosis or developmental delays? ___Yes ___No

If Yes, please explain:____

Is an Individual Health Plan required at school? _______ Yes ______ No

Any medical follow-up required? ______ Yes ______ No

If "Yes" please explain: ____

Based upon the medical history and physical condition at the time of this examination, she/he is free from communicable diseases and had received immunizations required by the state for admission to school under section 3313.671 of the Revised Code, or has had the immunizations required by the State Department of Health for Infants and Toddlers. In addition the child is in suitable condition for enrollment in a day care center.

Physician's Signature:____ **Date Physical given**: _____________

Business Address:____ Business Phone:_________________

* Hematocrit or Hemoglobin & Lead is **REQUIRED** by Head Start **If there are any questions or concerns regarding the requirements of this form, please contact the Health and Nutrition Manager at 440-242-2178** ***REVISED*** *9/2020BR*

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LEARNING COMMUNITY: ____________________CLASSROOM:__________ FSW_____________

SPECIAL DIET FORM

___________________________ _____________requires diet modifications due to the following:
Child's Name Birthdate

☐ **Religious Reasons (specific restriction/request :____)**
☐ **Parent Preference (specific restriction/request :____)**
☐ **Child has a disability (specific restriction/request :_______________________________________)**
☐ **Peanut Allergy**
☐ **Tree Nut Allergy**
☐ **Lactose/Milk Intolerance (must check one of the following boxes below)**
 ☐ Provide a diet that eliminates fluid milk and provide a Lactose Free Milk Substitute (requires Request for Medication Form).
 ☐ Provide a diet that eliminates fluid milk and all dairy based menu items and provide a Lactose Free Milk Substitute (requires Request for Medication Form).
☐ **Milk Allergy (must check one of the following boxes below)**
 ☐ Provide a diet that avoids all dairy based menu items and provide a Soy Milk Substitute (requires Request for Medication Form).
 ☐ Provide a diet that avoids all dairy based menu items and ingredients and provide a Soy Milk Substitute (requires Request for Medication Form).
☐ **Egg Allergy (must check one of the following boxes below)**
 ☐ Provide a diet that avoids egg based products (scrambled eggs, hard boiled eggs, custard)
 ☐ Provide a diet that avoids egg based products and foods with egg as an ingredient (muffins, snack crackers, ranch dressing)
☐ **Soy Allergy (must check one of the following boxes below)**
 ☐ Provide a diet that avoids liquid soy "milk substitute". If child also has a milk allergy, specify milk replacement: (requires Request for Medication Form ;) ____
 ☐ Provide a diet that avoids all soy based products and foods with soy ingredients.
☐ **Wheat Allergy (diet avoids all wheat ingredients)**
☐ **Gluten Allergy (diet avoids all wheat, rye, oats, barley)**
☐ **Shellfish Allergy (diet avoids all fish and shellfish)**
☐ Other Allergy/Intolerance: Specify: ____

- -

This is a (check one):

☐ Parent preference Signature: _________________________Date:________Phone #:______________

☐ Physician recommendation *(Requires a physician signature and may need a Request for Administration of Medication form to be completed, as noted above)*

Physician's Signature: ______________________________________Date:__________
Phone # _______________________

MR/RR Revised 2019

PLEASE RETURN IMMEDIATELY!