Klamath Family Head Start

1940 S. Sixth St. Klamath Falls, OR 97601 | Phone: 541 882-5988 | Fax: 541 884-2803

HEALTH EXAM

Date of Exam:_____ Class #_____

Child's Name:_____ Date of Birth:_____

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

Concern?	Yes	No
Allergies		
Ears/Nose/Throat		
Hearing		
Vision		
Lymph Nodes		
Cardiovascular System		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Immunizations		
Lead levels		
Hemoglobin/Hematocrit		
Dental: cavities or infection		
Other		

Please explain any concerns marked "yes":

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Well Child? Yes No

Name of Provider/Office:_____ Date completed:_____

Address:_____ Phone:_____

Signature of Provider:_____