

**BBNA Head Start**

PO Box 310 Dillingham, AK 99576  
907-842-4059

**Staff Physical Exam Form**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Health History (Please complete)**

	Yes	No
Heart disease	_____	_____
Seizure disorder	_____	_____
Diabetes	_____	_____
Thyroid or other metabolic disorder	_____	_____
Immune status disorder	_____	_____
Communicable disease	_____	_____
Any other medical condition	_____	_____

Please explain any "yes" responses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Exam (Please have completed by Health Care Provider)**

TB Test    Date given \_\_\_\_\_    Result and date read \_\_\_\_\_

Blood Pressure \_\_\_\_\_    Height \_\_\_\_\_    Weight \_\_\_\_\_

	Within Normal Limits	Yes	No
Eyes/Vision		_____	_____
Ears/Hearing		_____	_____
Cardiovascular system		_____	_____
Respiratory system		_____	_____
Skin		_____	_____
Neuro/musculoskeleton system		_____	_____
Endocrine system		_____	_____

Please explain "no" responses or note any concerns or conditions that might interfere with this person providing care for children:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can this person lift objects or children weighing up to 50 pounds? \_\_\_\_\_

\_\_\_\_\_  
Name of Physician/Health Care Provider    Signature of Provider    Date

\_\_\_\_\_  
Address