Physician Evaluation Form

College of Southern Idaho Head Start/ Early Head Start

Center address:	Phone:
City, State, Zip	Fax:
Contact person/title:	

TO BE COMPLETED BY HEAD START/ EARLY HEAD START

Child's name:_____ Date of Birth:_____

Date:_____ [] Has [] Has not been excluded from classroom/ socialization setting.

The following signs and /or symptoms have been noted in our daily health check observation:

HEALTH CARE PROVIDER,
PLEASE EVALUATE THIS CHILD AND COMPLETE THE REMAINDER OF THIS FORM

DIAGNOSIS

Diagnosis_____ [] Not communicable [] Communicable

TREATMENT/ MEDICATION

[] Medication given [] Other treatment recommended:

RETURN TO CHILD CARE

[] May return to child care/classroom/ socialization setting
[] Exclude until _____
Comments_____
HEALTH CARE PROVIDER SIGNAUTRE:_____
PHONE NUMBER_____ DATE:_____

Parent/ guardian must return this completed form to Head Start/ Early Head Start program in order for the child to return to class/socialization