EAST MISSOURI ACTION AGENCY, Inc.
Head Start

ASA INITIAL: _____

DATE ENTERED: _____

VERIFICATION OF HEALTH INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____

RESULTS

HEIGHT: _____ WEIGHT: _____

BP: _____* Abnormal-Greater than 112/88 (either number)

HEARING: R. EAR_____ L. EAR: _____ BOTH: _____

* Abnormal-Above 30 dbl in either ear

VISION: R. EYE_____ L. EYE: _____ BOTH: _____

* Abnormal- 20/50 and higher in either eye

PLUSOPTIX: PASS:_____ REFER:_____

HEAD START STAFF: _____DATE: _____