# CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME:______________________ SEX:________ BIRTHDATE:__________

HEAD START CENTER:______________________ PHONE:__________

ADDRESS:______________________

## PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

1. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations):*

2. SCREENING TESTS. *Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

| TEST | DATE | RESULTS | TEST | DATE | RESULTS |
|---|---|---|---|---|---|
| a. PRESENT AGE* | | ______Yrs., ______Mos. | g. VISION (Type of Test)*______ | | |
| b. HEIGHT (no shoes, to nearest 1/8 in.)* | | | ACUITY, R/L ______ | | |
| | | | RESCREENING ______ | | |
| c. WEIGHT (light clothing to nearest 1/4 lb.:)* | | | STRABISMUS ______ | | |
| | | | COMMENTS | | |
| d. BLOOD PRESSURE | | | h. OTHER TESTS (if indicated) | | |
| e. HEMATOCRIT or HEMOGLOBIN* | | | (1) TB ______ | | |
| f. HEARING (Type of Test)* ______ | | | (2) Sickle Cell ______ | | |
| RESULTS, R/L ______ | | | (3) Lead ______ | | |
| RESCREENING ______ | | | (4) Ova & Parasites ______ | | |
| COMMENTS | | | (5) Urinalysis ______ | | |
| | | | (6) Other ______ | | |

## PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start.*

| | NORMAL FOR AGE | ABNORMAL | NOT EVAL. | COMMENTS *(Use Additional sheet if necessary)* |
|---|---|---|---|---|
| a. GENERAL APPEARANCE | | | | |
| b. POSTURE, GAIT | | | | |
| c. SPEECH | | | | |
| d. HEAD | | | | |
| e. SKIN | | | | |
| f. EYES: (1) External Aspects | | | | |
| (2) Optic Fundiscopic | | | | |
| (3) Cover Test | | | | |
| g. EARS: (1) External & Canals | | | | |
| (2) Tympanic Membranes | | | | |
| h. NOSE, MOUTH, PHARYNX | | | | |
| i. TEETH | | | | |
| j. HEART | | | | |
| k. LUNGS | | | | |
| l. ABDOMEN (include hernia) | | | | |
| m. GENITALIA | | | | |
| n. BONES, JOINTS, MUSCLES | | | | |
| o. NEUROLOGICAL/SOCIAL | | | | |
| (1) Gross Motor______ | | | | |
| (2) Fine Motor______ | | | | |
| (3) Communication Skills______ | | | | |
| (4) Cognitive______ | | | | |
| (5) Self-Help Skills______ | | | | |
| (6) Social Skills | | | | |
| p. GLANDS (Lymphatic/Thyroid) | | | | |
| q. MUSCULAR COORDINATION | | | | |
| r. OTHER | | | | |

# HEAD START

**ATTENTION: HEALTH CARE PROVIDERS**

Due to Federal guidelines that our program **must** meet, it is absolutely essential that this form be completed and signed. Please complete [illegible]

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature:______________________ Date:__________

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

| | ABNORMAL FINDINGS/DIAGNOSIS | TREATMENT PLAN | RECOMMENDED FOLLOW-UP OR RESULTS *(Initial when complete)* | DATE |
|---|---|---|---|---|
| a. | | | | |
| b. | | | | |
| c. | | | | |
| d. | | | | |

(COMPLETE AT INTERVIEW)

CHILD'S NAME:______ SEX:______ BIRTHDATE:______

HEAD START CENTER:______ PHONE:______

ADDRESS:______

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No_____Unknown_____Yes_____
   - Fluoridated water? No_____Unknown_____Yes_____
   - Fluoride Supplement diet? No_____Unknown_____Yes_____
     (tablets_____, liquid_____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD START STAFF

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name______ Date last visit______
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name______
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type______
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Allergies | ___ | ___ | Liver Dis. | ___ | ___ |
| Asthma | ___ | ___ | Rheumatic Fever | ___ | ___ |
| Bleeding | ___ | ___ | Sickle Cell Dis. | ___ | ___ |
| Diabetes | ___ | ___ | Other (List Below) | ___ | ___ |
| Epilepsy | ___ | ___ | ______ | | |
| Heart/Vascular Dis. | ___ | ___ | ______ | | |

# HEAD START

**ATTENTION: HEALTH CARE PROVIDERS**

Due to Federal guidelines that our program **must** meet, it is absolutely essential that this form be completed and signed. Please complete **section 9-12 and sign and date.**

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (●), or filled (■); indicate restorations you perform in Item 10.*

UPPER: D E F G, C LINGUAL H, B I, A J, 3 14
RIGHT LEFT
LOWER: 30 19, T K, S L, R LINGUAL M, Q P O N

10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

| Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Service Performed MO. | DAY | YR. | A.D.A. Procedure Number | Actual Charges (Fee) |
|---|---|---|---|---|---|---|---|---|
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11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits______. Approximate cost______.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.
   ______
   ______
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature______ Date______

INTERVIEWER: GO TO FORM 6