

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

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

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

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 _____		
c. WEIGHT (light clothing to nearest 1/4 lb.)*			RESCREENING _____		
d. BLOOD PRESSURE			STRABISMUS _____		
e. HEMATOCRIT or HEMOGLOBIN*			COMMENTS _____		
f. HEARING (Type of Test)*			h. OTHER TESTS (if indicated)		
RESULTS, R/L _____			(1) TB _____		
RESCREENING _____			(2) Sickle Cell _____		
COMMENTS _____			(3) Lead _____		
			(4) Ova & Parasites _____		
			(5) Urinalysis _____		
			(6) Other _____		

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

	NORMAL FOR AGE	ABNORMAL	NOT EVAL
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			

COMMENTS (Use Additional sheet if necessary)

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 _____

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.			

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

