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

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

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

SECTIONS BELOW TO BE COMPLETED BY PHYSICIAN

2. SCREENING TESTS. (*) REQUIRED by Head Start. Enter dates if done previously.

TEST	DATE	RESULTS
a. PRESENT AGE*		___Yrs.___Mos.
b. HEIGHT (no shoes, to nearest 1/8 in.)*		
c. WEIGHT (light clothing to nearest ¼ lb.)*		
d. BMI		
e. BLOOD PRESSURE*		
f. TEMPERATURE		
g. RESPIRATION		

(*) REQUIRED by Head Start. Enter dates if done previously.

h. HGB/HCT: _____ DATE: _____
□ Normal □ Abnormal
TX: _____

i. LEAD: _____ DATE: _____
□ Normal □ Abnormal
TX: _____

j. VISION (Type of test): _____ *
DATE: _____
ACUITY, R/L: _____
STRABISMUS: _____
COMMENTS: _____

k. HEARING (Type of test): _____ *
DATE: _____
RESULTS, R/L: _____
COMMENTS: _____

TEST	DATE	RESULTS
l. OTHER TESTS (if indicated)		
(1) TB		
(2) SICKLE CELL		
(3) OVA & PARASITES		
(4) URINALYSIS		
(5) OTHER: _____		

3. PHYSICAL EXAMINATION/ASSESSMENT.

	NORMAL	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 Aspects				
(2) Tympanic				
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				

Does the child have a diagnosed chronic condition? YES NO
Diagnosis _____
Date of Diagnosis _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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

5. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

By signing below and according to the information provided above, the child is determined to be up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental, and mental health.

Physician's Signature: _____ Health Determination Date: _____