Child's Physical Form

Child's Name:_________________________________ Sex: _______ Birthdate: __________________

Head Start Center: _______________________________________ Phone: ______________________

Head Start Address: ____

1. Relevant Information: (Observation from Parent/Teacher)

2. Screening Tests, (*) Items are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously.

Test	Date	Results		Test	Date	Results
Present Age*		___ Yrs.	___ Mos.	Vision*		R:_____ L:_____
Height (no shoes to the nearest 1/8 in)*				Type of Test ________________		Both: _________
Weight (Light clothes to the nearest 1/4 lb.*				Tests		
				Lead*		
Blood Pressure: *				Hemo*		
Hearing* Type of Test ________________		R:_____	L:____	Other		
		Both: ___				

3. Physical Examination/Assessment

	Normal Age	Abnormal	Not Eval.		Normal Age	Abnormal	Not Eval
General Appearance				Bones, Joints, Muscles			
Posture/Gait				Glands			
Head				Muscular Coordination			
Skin				Speech			
Eyes- External				Neuro			
Optic Fundiscopic				Gross Motor			
Cover Test				Fine motor			
Ears: External & Canals				Communication			
Tympanic Membranes				Cognitive			
Nose, Mouth, Pharynx				Self Help			
Teeth							
Heart				Other			
Lungs							
Abdomen							
Genitalia							

Comments:

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.
(Date of medical examination must be within the last 12 months.)

Signature:_______________________________________ Date:___________________________

May-24