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

s. 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:_____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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