

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	ABNOR. MAL	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 Fundleoscopic				
(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				

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