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 ____		
			RESCREENING ____		
c. WEIGHT (light clothing to nearest 1/4 lb.)*			STRABISMUS ____		
			COMMENTS		
d. BLOOD PRESSURE					
e. HEMATOCRIT or HEMOGLOBIN*			h. OTHER TESTS (If Indicated) (1) TB ____		
f. HEARING (Type of Test)* ____			(2) Sickle Cell ____		
RESULTS, R/L ____			(3) Lead ____		
RESCREENING ____			(4) Ova. & Parasites ____		
COMMENTS			(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	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 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				Please print doctor's name.

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.				