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 inch)*			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 two copies to Head Start.

	NORMAL FOR AGE	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 & 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) Socials 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