

CHILD HEALTH RECORD:

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 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				

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