

# CHILD HEALTH RECORD: SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
 HEAD START CENTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_

1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):

## SECTIONS BELOW TO BE COMPLETED BY PHYSICIAN

2. SCREENING TESTS. (\*) REQUIRED by Head Start. Enter dates if done previously.

TEST	DATE	RESULTS	
a. PRESENT AGE*		___ Yrs., ___ Mos.	j. VISION (Type of test): _____ * DATE: _____ ACUITY, R/L: _____ STRABISMUS: _____ COMMENTS: _____
b. HEIGHT (no shoes, to nearest 1/8 in.)*			
c. WEIGHT (light clothing to nearest 1/4 lb.)*			
d. BMI			
e. BLOOD PRESSURE*			k. HEARING (Type of test): _____ * DATE: _____ RESULTS, R/L: _____ COMMENTS: _____
f. TEMPERATURE			
g. RESPIRATION			
(*) REQUIRED by Head Start. Enter dates if done previously.			TEST                      DATE                      RESULTS
h. HGB/HCT: _____ DATE: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal  TX: _____			l. OTHER TESTS (if indicated) (1) TB
i. LEAD: _____ DATE: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal  TX: _____			(2) SICKLE CELL (3) OVA & PARASITES (4) URINALYSIS (5) OTHER: _____

3. PHYSICAL EXAMINATION/ASSESSMENT.

	NORMAL	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 Aspects				
(2) Tympanic				
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				

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS <i>(Initial when complete)</i>	DATE
a.			
b.			
c.			

5. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_