CHILD HEALTH RECORD: FORM 3, 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.
b. HEIGHT (no shoes, to nearest 1/8 in.)*		
c. WEIGHT (light clothing to nearest ¼ lb.)*		
d. BMI		
e. BLOOD PRESSURE*		
f. TEMPERATURE		
g. RESPIRATION		

(*) REQUIRED by Head Start. Enter dates if done previously.

h. HGB/HCT:_____ DATE: _____
□ Normal □ Abnormal
TX: _____

i. LEAD:_____ DATE: _____
□ Normal □ Abnormal
TX: _____

j. VISION (Type of test): _____
* DATE: _____
ACUITY, R/L: _____
STRABISMUS: _____
COMMENTS: _____

k. HEARING (Type of test): _____
* DATE: _____
RESULTS, R/L: _____
COMMENTS: _____

TEST	DATE	RESULTS
l. OTHER TESTS (if indicated)		
(1) TB		
(2) SICKLE CELL		
(3) OVA & PARASITES		
(4) URINALYSIS		
(5) OTHER: _____		

3. PHYSICAL EXAMINATION/ASSESSMENT.

	NORMAL	ABNORMAL	NOT EVAL.
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			

COMMENTS *(Use Additional sheet if necessary)*

Does the child have a diagnosed chronic condition? YES NO
Diagnosis _____
Date of Diagnosis _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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

5. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

By signing below and according to the information provided above, the child is determined to be up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental, and mental health.

Physician's Signature: _____ Health Determination Date: _____

Please Return to:
Attn: Sheena Lewis
P.O. Box 208
Erin, TN 37061
Phone: 931-289-4135 Fax: 931-289-3220