CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION ASSESSMENT

Child's Name:_____ Sex: ____ Birthdate:_____

Head Start Center: **Humeston Head Start** Phone: 641-877-2521

SCREENING TESTS: *Stared 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
PRESENT AGE		____Yrs. ____Mo.			
HEIGHT (no shoes, to Nearest 1/8 in)***REQUIRED**			VISION (Type of Test)*____	_____	_____
WEIGHT (light clothing To nearest ¼ lb) ***REQUIRED**			Acuity, R/L _____	_____	_____
			RESCREENING _____	_____	_____
			STRABISMUS _____		
			COMMENTS:		
BLOOD PRESSURE ***REQUIRED**			OTHER TESTS (If Indicated)		
HEMATOCRIT or HEMOGLOBIN ***REQUIRED**			TB _____	_____	_____
HEARING (Type of test) _____	_____	R _____ L _____	Sickle Cell_____	_____	_____
_____	_____	_____	Lead ***REQUIRED**_____	_____	_____
Rescreening_____			Ova & Parasites _____	_____	_____
Comments:			Urinalysis_____	_____	_____
			Other _____	_____	_____
			_____	_____	_____

PHYSICAL EXAMINATION ASSESSMENT

	NORMAL FOR AGE	ABNORMAL	NOT EVAL	COMMENTS (Use Additional sheet if necessary_
GENERAL APPEARANCE				
POSTURE, GAIT				
SPEECH				
HEAD				
SKIN				
EYES (1) External Aspects (2) Optic Fundiscopic (3) Cover Test	_____ _____	_____ _____	_____ _____	
EARS (1) External & Canals (2) Tympanic Membranes	_____	_____	_____	
NOSE, MOUTH, PHARYNX				
TEETH				
HEART				
LUNGS				
ABDOMEN (Include hernia)				
GENITALIA				
BONES, JOINTS, MUSCLES				
NEUROLOGICAL/SOCIAL (1) Gross Motor_____ (2) Fine Motor _____ (3) Communication Skills _____ (4) Cognitive _____ (5) Self-Help Skills_____ (6) Social Skills _____	 _____ _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____ _____	 _____ _____ _____ _____ _____ _____	
GLANDS (Lymphatic/Thyroid)				
MUSCULAR COORDINATION				
OTHER				

GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature _____ Date _____

FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS (Initial when complete)	DATE