CHILD HEALTH RECORD: SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT
2016-2017 School Year

CHILD'S NAME: ____ SEX: _________ BIRTHDATE: ______________________

ADDRESS: ____ PHONE: ____________________________

1. RELEVANT HEALTH INFORMATION (LIST ANY LIMITATIONS OR HEALTH CONDITIONS FOR THIS CHILD, INCLUDING ALLERGIES, DAILY MEDICATION, DIETARY RESTRICTIONS.)

2. SCREENING TESTS – *All items below are **required** by Head Start and recommended by the American Academy of Pediatrics and the Ohio EPSDT 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	f. HEIGHT (no shoes)		
b. WEIGHT (light clothing)			g. BLOOD PRESSURE		
c. BODY MASS INDEX (BMI)			h. LEAD SCREENING		
d. HEMATOCRIT OR HEMOGLOBIN			i. VISION (Type of Test)		
e. HEARING (Type of Test)			Acuity, R/L		
Results, R/L			Rescreening Recommended		_____Yes _____No
Rescreening Recommended		_____Yes _____No	Strabismus		
Comments			Comments		

3. PHYSICAL EXAMINATION/ASSESSMENT: **DATE OF EXAMINATION:** ____________________________

	NORMAL FOR AGE	ABNOR MAL	NOT EVAL.		NORMAL FOR AGE	ABNOR MAL	NOT EVAL.
a. GENERAL APPEARANCE				l. ABDOMEN (include hernia)			
b. POSTURE, GAIT				m. GENITALIA			
c. SPEECH				n. BONES, JOINTS, MUSCLES			
d. HEAD				o. NEUROLOGICAL/SOCIAL			
e. SKIN				(1) Gross Motor			
f. EYES (1) External Aspect				(2) Fine Motor			
(2) Optic Funduscopic				(3) Communication Skills			
(3) Cover Test				(4) Cognitive			
g. EARS (1) External & Canals				(5) Self-Help Skills			
(2) Tympanic Membranes				(6) Social Skills			
h. NOSE, MOUTH, PHARYNX				p. GLANDS (Lymphatic/Thyroid)			
i. TEETH				q. MUSCULAR COORDINATION			
j. HEART				r. OTHER			
k. LUNGS							

s. GENERAL STATEMENT ON CHILD'S PHYSICAL HEALTH:

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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

5. ANTICIPATORY GUIDANCE (please check any anticipatory guidance presented to family)

☐ Injury Prevention ☐ Violence Prevention ☐ Sleep Positioning Counseling ☐ Nutrition Counseling ☐Other ____________

I have examined this child and found that he or she is in suitable condition for participation in group care. My office has attached a record of the immunizations or found that this child should be exempt from immunizations for the following reasons: ______________

____

This child is up-to-date on a schedule of age appropriate preventive and primary health care. ______Yes ______No

If No, Why ____

Physician Printed Name: ____________________________________ Phone: ________________________
Required Required

Physician Signature: ______________________________________ Date: ________________________
Required Required

Physician Address: ____
Street City State Zip

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