

RETURN TO: Tioga Opportunities Inc., Head Start
1277 Taylor Rd. Owego, New York 13827 (607) 687-5888 (607) 687-5904 Fax

CHILD HEALTH RECORD: PHYSICAL EXAMINATION / ASSESSMENT

CHILD'S NAME: _____ SEX: Male Female BIRTHDATE: ____/____/____
HOME ADDRESS _____ PHONE: _____

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

2. ALLERGIES: Medication, Food, or Other:

3. SCREENING TESTS, Stared Items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter results and dates if done previously.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE *		Yrs. Mos.	g. VISION (Type of Test) * ACUITY, R/L STRABISMUS COMMENTS	_____	_____
b. HEIGHT (no shoes, to nearest 1/8 in.) *			h. HEARING (Type of Test) * RESULTS, R/L	_____	_____
c. WEIGHT (light clothing to nearest 1/4 lb.) *			i. OTHER TESTS (if indicated) 1. TB 2. Sickle Cell 3. Urinalysis 4. Ova & Parasites 5. Other	_____	_____
d. BLOOD PRESSURE				_____	_____
e. HEMATOCRIT or HEMOGLOBIN *				_____	_____
f. LEAD *				_____	_____
COMMENTS:					

4. PHYSICAL EXAMINATION / ASSESSMENT

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

r. To the best of my knowledge this child is free from contagious and communicable diseases and is physically able to attend Head Start.
Yes _____ No _____

STAMP / DEA # _____
Signature: _____ **Date:** _____

5. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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