El Grito Head Start

PHYSICAL EXAMINATION FORM

P.O. Box 1536, 303 S. Cooper St. Silver City, New Mexico 88062
Phone: (575)538-5459 or (575)388-8861
Fax: (575)538-3607

CHILD'S NAME:______________________ SEX:________ BIRTHDATE:____________

PLEASE INCLUDE RESULTS ON SECTION d) BLOOD PRESSURE (e) HEMATOCRIT/ HEMAGLOBIN OR SECTION (h)

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

2. SCREENING TESTS. *Starred 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
a. PRESENT AGE*		______YRS. ______MOS.	g. VISION (Type of Test)*		
b. HEIGHT (no shoes, to nearest 1/8 in.) *			ACUITY, R/L		
c. WEIGHT (light clothing to nearest ¼ lb. :)			RESCREENING		
d. BLOOD PRESSURE			STRABISMUS		
e. HEMATOCRIT or HEMOGLOBIN*			COMMENTS		
f. HEARING (Type of Test)*			h. OTHER TESTS (If Indicated)		
RESULTS, R/L			(1) TB		
RESCREENING			(2) Sickle Cell		
COMMENTS			(3) Lead		
			(4) Ova & Parasites		
			(5) Urinalysis		
			(6) Other________		

TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER EXAMINATION(

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start*

	NORMAL FOR AGE	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 & Canais				
(2) Tympanic Membranes				
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) Fognitive				
(5) Self-Help Skills				
(6) Social Skills				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

s. GENERAL STATEMENT ON CHILD;S PHYSICAL STATUS:

Signature:______________________ Date:____________

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

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