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

Physical to Be Completed By Head Start Staff Or Health Care Provider Physical Examination

CHILD'S NAME: **SEX:** **BIRTH DATE:**

HEAD START CENTER: **PHONE:**

ADDRESS:

1. RELEVANT 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, Ft/L		
			RESCREENING		
c. WEIGHT (light clothing to nearest 1/4 lb.**			STRABISMUS		
			COMME		
d. BLOOD PRESSURE					
e. HEMATOCRIT or HEMOGLOBIN'			h. OTHER TESTS (if indicated) (1) TB/PPD		
f. HEARING (Type of Test)*			(2) Sickle Cell		
RESULTS, RIL			(3) Lead		
RESCREENING			(4) Ova & Parasites		
			(5) Urinalysis		
			(8) Other		

3. PHYSICAL EXAMINATION/ ASESSMENT	NORMAL FOR AGE	ABNOR-MAL	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 Fundoscopic				
(3) Cover Test				
g. EARS: (1) External & Canals				
(2) Tympanic Membranes				
h. NOSE, MOUTH, PHARYNX				
I. TEETH				
j. HEART				
k. LUNGS				
I. 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				
(8) Social Skills				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

This form MUST be completed for Head Start. Everything must have "current year" and ALL highlighted areas need be completed. Tests: TB/PPD (risk assessment or note from MD stating child not at risk acceptable), H & H and lead must be current. Sickle Cell results needed (can be newborn results).

IMPORTANT: If child has ASTHMA and/or an ALLERGY, you MUST complete and submit the following: (1) Asthma Action Plan and/or a (2) Individual Allergy & Anaphylaxis Emergency Plan (OCFS-6029). Both of these conditions also requires the Individual Plan for Child with Special Needs (OCFS LDSS 7006) and Medication Consent Forms (OCFS LDSS 7002)!

Note: If needed, the OCFS forms can be obtained online.

PLEASE STAMP

HEALTH SPECIFICS AND GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Are there any allergies? ☐ **YES** ☐ **NO** **If YES, please compete OCFS 6029, OCFS 7002 and OCFS 7006 as indicated above.**

Is medication regularly taken? ☐ **YES** ☐ **NO** **If YES, specify drug and condition:** _____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ **YES** ☐ **NO**

Signature _____ Date __________**2023**

4. Findings ,Treatments and recommendations Abnormal Findings/ Diagnosis	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS *(Initial when complete)*	DATE
a.			
b.			
c.			
d.			

CHILD HEALTH RECORD FORM 4. IMMUNIZATIONS

CHILD'S NAME _____SEX _____ BIRTHDATE _____

HEAD START CENTER: _____ PHONE _____

ADDRESS _____

PARENT OR GUARDIAN _____ ADDRESS _____

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1. IMMUNIZATIONS

VACCINE	DATE GIVEN DAY/MO/YR	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
DTP			
TD/DT			
POLIO - OPV			
MMR			
HIB (IF POSSIBLE SPECIFY VACCINE, HBOC, PRP – OMP, OR PRP-D)			
HB (AT BIRTH)			
HBIG (AT BIRTH)			
HEP A			
VARICELLA			
PNEUMOCOCCAL			
PREVNAR (PCV)			
Rotavirus			

2. CERTIFICATION OF PREVIOUS IMMUNIZATIONS:

I hereby attest that I have seen documentation of any immunizations the child received prior to enrollment in Head Start.

Signature_____ Title _____Date _____