HEAD START OF WASHINGTON COUNTY
PHYSICAL FORM

131 W. North Ave.
Hagerstown, MD 21740

Phone (301) 797-5231
Fax (301) 797-5364

TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME:_____ SEX: M F BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

STREET ADDRESS:_____

CITY:_____ ST:____ ZIP:_____

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 ages 3 to 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
a. **PRESENT AGE ***		**Yrs.** **Mos.**
b. **HEIGHT *** *(no shoes, to nearest 1/8 in.)*		
c. **WEIGHT *** *(light clothing to nearest 1/4 lb.)*		
d. BLOOD PRESSURE		
e. **HEMATOCRIT OR HEMOGLOBIN ***		
f. HEARING *		
*(Type of Test)**		
RESULTS, R / L		
RESCREENING		
COMMENTS:		

TEST	DATE	RESULTS
g. VISION *		
*(Type of Test)**		
ACUITY, R / L		
RESCREENING		
STRABISM US		
COMMENTS:		
h. OTHER TESTS *(if indicated)*		
(1) TB*		
(2) Sickle Cell		
(3) Lead *		
12 Months		
24 months		
(4) Ova & Parasites		
(5) Urinaly sys		

TO BE COMPLETED BY HEALTH PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION / ASSESSMENT *Complete and return to HEAD START*

	NORMAL FOR AGE	ABNORMAL	NOT EVAL
a. GENERAL APPEARANCE			
b. POSTURE, GAIT			
c. SPEECH			
d HEAD			
e. SKIN			
f. EYE: (1) External Aspects			
(2) Optic Fundiscopic			
(3) Cover Test			
g. EARS (1) External Aspects			
(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) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
p. GLANDS (lymphatic/Thyroid			
q. MUSCULAR COORDINATION			
r. OTHER			

s. *GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS*

4. ABNORMAL FINDINGS, TREATMENTS, AND RECOMMENDATIONS AND FOLLOW-UP

a.
b.
c.
d.

Date :_____

Signature:_____

DATE OF NEXT WELL CHILD CHECK:_____

BLOOD LEAD LEVELS IS A REQUIRED FIELD

Head Start requires all areas of this form to be completed.

TO BE COMPLETED BY HEALTH PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ ASSESSMENT