Please check one (Provider Use Only):
- ☐ 3 year old physical exam
- ☐ 4 year old physical exam
- ☐ 5 year old physical exam

Early Childhood Development and Health Services

Physical Exam

Students Name________________________________ Date of Birth______________________

Parent/Guardian Name__________________________ Phone #__________________________

Address ____

The child listed above is being evaluated for readiness to enter Preschool. OCHS operates part day and full day programs. Utilizing this form, please provide up-to-date information on the child referenced above.

Exchange of Information/ Intercambio de Información

As the parent of the child referenced above, I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.

Como el padre/tutor del niño identificado en este formulario, yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.

Parent Signature/*Firma de Padre* ______________________________ Date/*Fecha* ________________

HEAD START follows the CHDP requirements. Please do not leave any of the below sections blank*

Required TB Screening

- ☐ **Screened, not at risk**
- ☐ **Screened, at risk**

TB Skin Test (Required if at risk; result within last 12 months)

Date Given ________________
Date Read ________________
Result ____________________
If Positive:
Chest X-Ray Date ____________
Result ____________________

Lead

- ☐ **Screened, not at risk**
- ☐ **Screened, at risk**

Follow-up Appointment Date: ____________

General Health

Height _________ Weight _________

Blood Pressure ________________

Hemoglobin/Hematocrit Test

- ☐ **Screened, no concern**
- ☐ **Screened, concern noted**

Follow-up Appointment Date:
____

Attach Copy of Up-to-Date Immunization Records

Visual Acuity Screening

Passed R: 20/ _____ L: 20/ _____

Failed R: 20/ _____ L: 20/ _____

☐ Unable to condition
Referred to ________________

Audiometric Screening

R: ☐ Passed ☐ Failed
L: ☐ Passed ☐ Failed
☐ Unable to condition
Referred to ________________

PHYSICAL EXAM ***(Complete all three sections)***

	NORM	ABNORM		NORM	ABNORM		NORM	ABNORM
GEN.APPEARANCE			HEART			MOTOR ABILITY		
POSTURE/GAIT			LUNGS			SELF/HELP SOCIAL SKILLS		
SPEECH			ABDOMEN			COMMUNICATION SKILLS		
HEAD/NECK			GENITALIA			COGNITIVE SKILLS		
EYES			BONES/JOINTS/MUSCLE			ORAL HEALTH SERVICES PROVIDED (3YR PHYSICAL ONLY)	YES	NO
EARS			SKIN					
NOSE			BACK			**If No,** was the child referred to a Dental Home?	YES	NO
GLANDS			MUSCULAR COORDIN.					

Asthma/Allergy: ☐ **Yes** (specify below) ☐ **No**   **Requires Medication at School:** ☐ **Yes** ☐ **No**

Explain any abnormal findings/statement of health:

____

____

Referred to: ______________________________ For: ______________________________

Physician Information (Stamp)
Name:
Address:
Phone:

Signature: ______________________
Fax: ______________________
Date of Exam: ______________________

Rev 8/8/16