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

Orange County Head Start, Inc.

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.

Là Phụ huynh của con tôi sau đây. Tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho cơ quan Quận Cam Head Start, Inc.

Parent Signature/*Phụ Huynh Ký tên*_____ Date/*Ngày* _____

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: _____