

3-5

YEARS OLD

PHYSICAL EXAMINATION FORM**PATIENT INFORMATION**

Child's Name _____

Date of Birth _____

HEAD START follows the AAP Bright Futures EPSDT requirements. Please do not leave any of the below sections blank.**REQUIRED TB SCREENING**

- NOT at risk
- AT RISK (Skin Test Required)
 Results must be within last 12 months
 Date Given: _____
 Date Read: _____
 Results: _____ mm Negative Positive
- If Positive,
 Chest X-Ray Date: _____ Result: _____

PHYSICAL EXAMINATION

Screening Requirement	Normal	Abnormal
General Appearance		
Blood Pressure		
Arms/Legs		
Eyes		
Ear/Nose/Throat		
Skin		
Muscles/Bones/Joints		
Heart		
Lungs		
Urinary/Genitalia		
Stomach/GI		
Glands/Lymphatic/Thyroid		
Neurological/Cognitive		
Motor Ability		
Speech/Communication		

IF A CONCERN IS PRESENT, PLEASE EXPLAIN:

Developmental Surveillance	No Concern	Concern
Psychosocial/Behavioral Assessment	No Concern	Concern
Oral Health Risk Assessment	No Concern	Concern
Fluoride Varnish Applied	Yes	No
Anticipatory Guidance Given	Yes	No

REQUIRED TESTS/EVALUATIONS

Growth Assessment: Height: _____ Weight: _____
Dyslipidemia Screening (4 YR PE): Not at risk At Risk

Hemoglobin/Hematocrit
 Normal/No Concern Abnormal → Results: _____
 Iron Rx: Yes No Re-Check Due By: _____

Lead Screening Not at risk
 At risk → Lead Value: _____ Follow-Up Appt: _____

Visual Acuity Screening

RIGHT EYE LEFT EYE

Passed
 Failed/Refer
 Uncooperative
 Referred to: _____

Audiometric Screening

RIGHT EAR LEFT EAR

Passed
 Failed/Refer
 Uncooperative
 Referred to: _____

IS CHILD UNDER TREATMENT FOR ANY OF THE FOLLOWING?

Asthma Yes No
 Severe Allergy: _____ Yes No
 Other: _____ Yes No
 Are emergency medications needed at school? Yes No

Explain any abnormal findings and restrictions/recommendations for school:

HEAD START STAFF ONLY

Date Received (Stamp):

PROVIDER USE ONLY

Office Stamp:

EXAM DATE:

Physician:

Phone/Fax:

Signature: