3-5
YEARS OLD

Orange County Head Start, Inc.
Empowering Children & Families

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 ONY

Office Stamp:	**EXAM DATE:**
	Physician:
	Phone/Fax:
	Signature:

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