Orange County Head Start, Inc.
Empowering Children & Families

HS

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.

PLEASE INDICATE WHICH PHYSICAL EXAM THIS IS (Provider Use Only): ☐ **3 YEAR** ☐ **4 YEAR** ☐ **5 YEAR**

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
Behavioral/Social/Emotional Screening	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**

Anemia Screening: ☐ **Not at risk**

☐ **At risk** → **Hemoglobin or Hematocrit Value:** _____

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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