Columbiana County Head Start
7880 Lincole Place
Head Start Center: Lisbon, OH 44432 (330) 424-7221

Child's Name: _____ Sex: _____ Birthdate: _____

Address _____ Phone: _____

1. Relevant Information

2. Screening Tests: Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. **Enter dates if done previously.** When recording results, enter at a minimum "N" Normal "S" Suspect, or "A" for Atypical/Abnormal.
(* Required screens: Height, Weight, Hearing, Vision, Lead, and either Hematocrit or Hemoglobin)

Test	Date	Results	Test	Date	Results
a. **Present age**		____Yrs. ____Mos.	h. **Vision** (Type of Test)*		
b. **Height** (no shoes to nearest 1/8 in.) *			Acuity R / L		
			Re-screening		
			Strabismus		
			Comments		
c. **Weight** (light clothing to nearest ¼ lb.)*			i. **Other Tests** (If Needed)		
d. **Blood Pressure**					
			(1) TB		
e. **Hematocrit** or **Hemoglobin** *			(2) Sickle Cell		
			(3) Ova & Parasites		
f. **Hearing** (Type of Test) *			(4) Urinalysis		
Results R / L *			5) Other		
Re-screening					
Comments					
g. **Lead** *					

3. Physical Examination Assessment

	Normal For Age	Abnormal	Not Eval.
a. General Appearance			
b. Posture			
c. Speech			
d. Head			
e. Skin			
f. Eyes 1) External Aspects			
2) Optic Fundiscopic			
3) Cover Test			
g. Ears 1) External & Canals			
2) Tympanic Membranes			
h. Nose, Mouth, Pharynx			
i. Teeth			
j. Heart			
k. Lungs			
l. Abdomen (include hernia)			
m. Genitalia			
n. Bones, Joints, Muscles			
o. Neurological/Social			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
p. Glands (lymphatic/Thyroid)			
r. Other			

	First	Second	Third	Fourth	Fifth
Polio					
DTaP					
MMR					
Hib					
Hepatitis B					
Varicella					
Hepatitis A					
PCV					
Influenza					
Other 1					
Other 2					
Other 3					

Additional Comments (Use additional sheet if necessary)

s. **General Statement on Child:** This child has been found to be free of Communicable Disease and is in suitable condition to participate in a child care setting.

Name of Physician (Please Print)	Telephone Number ( )
Street Address	
City, State and Zip Code	
Physician's Signature:	Date of Physician's Signature

White Copy: Office **Yellow Copy:** Center **Pink Copy:** Other Rev. 07/08