

**BISHOP INDIAN HEAD START  
CHILD HEALTH RECORD- SCREENINGS, PHYSICAL EXAMINATION, TB ASSESSMENT**



PART 1. TO BE COMPLETED BY HEALTH CARE PROVIDER PRIOR TO PHYSICAL EXAMINATION/ ASSESSMENT.

Child's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Head Start Center: **Bishop Indian Head Start/State Preschool** HmPh 1: \_\_\_\_\_ HmPh 2: \_\_\_\_\_  
 Mailing Address: **50 Tu Su Lane Bishop, CA 93514** Office Ph: **(760) 872-3911** FAX: **(760) 872-4857**

**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, circle "N" = Normal; "S" = Suspect, or "A" =Atypical/Abnormal.

TEST	DATE	RESULTS		TEST	DATE	RESULTS
* Present Age		Yrs,	Mos.	* <b>Hearing</b> (specify type of test)		
* Height (no shoes, nearest 1/8")				Results		
* Weight (light clothes, nearest 1/4 lb)				Rescreening		
* Blood Pressure						
* HGB/HCT (Hemoglobin/Hematocrit)						
* Sickle Cell <input type="checkbox"/> Not routinely screened		N	S	A	* <b>Vision</b>	
* Lead <input type="checkbox"/> Headstart screening		N	S	A	Acuity R/L	
* Urinalysis		N	S	A	Rescreening	
Ova, Parasites <input type="checkbox"/> Not routinely screened		N	S	A	Strabismus	
Other (Indicate)					Comments	

Part 2. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING PHYSICAL EXAMINATION/ ASSESSMENT

3. PHYSICAL EXAMINATION/ ASSESSMENT	Normal for Age	Abnormal	Not evaluated
A. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Eyes (external and optic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Ears (external and tympanic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Abdomen (includes Hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Bones, Joints, Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Neurological/ Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(1) Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(2) Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(3) Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(4) Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(5) Self-Help Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(6) Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Glands (Lymphatic/ Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S. General Statement of Child's Physical Status:			

**TB RISK FACTORS/ TB WAIVER:**

Risk Factors **Not Present**; TB Skin test not required

Risk Factors **PRESENT**; Mantoux TB test performed:  
**Date Test Performed:** \_\_\_\_\_  
 Neg  Pos

**Risk Factors for TB in Children**  
 →Have clinical evidence of TB  
 →Have Abnormalities on chest x-ray suggestive of TB  
 →Have contact w/or family hx of confirmed/suspected TB and/or HIV seropositivity  
 →Are in foreign-born families w/high prevalence countries  
 →Live in and out of home placements  
 →Live w/someone who has been incarcerated in the past 5yrs.  
 →Live among or are frequently exposed to, individuals who are homeless, migrant farm wrks, users of street drugs or nursing home residents

Immunizations	Given Today	
	Up-to-date for age	Still not up-to-date for age
IPV		
Hib		
Hep B		
MMR		
Varicella		
Hep A		
PCV-13		

Medications: \_\_\_\_\_

**Food/Other Allergies/Asthma:** \_\_\_\_\_

**Sign & Date:** \_\_\_\_\_

**4. COMMENTS (please print clearly)** \_\_\_\_\_

CARE PROVIDER'S CLINIC STAMP