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
* **Present Age**		Yrs, Mos.
* **Height** (no shoes, nearest 1/8")		
* **Weight** (light clothes, nearest 1/4 lb)		
* **Blood Pressure**		
* **HGB/HCT** (Hemoglobin/Hematocrit)		
* **Sickle Cell** ☐	Not routinely screened	N S A
* **Lead** ☐	Headstart screening	N S A
* **Urinalysis**		N S A
Ova, Parasites ☐	Not routinely screened	N S A
Other (Indicate)		

TEST	DATE	RESULTS
* **Hearing** (specify type of test)		
Results		
Rescreening		
* **Vision**		
Acuity R/L		
Rescreening		
Strabismus		
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	☐	☐	☐
B. Posture, Gait	☐	☐	☐
C. Speech	☐	☐	☐
D. Head	☐	☐	☐
E. Skin	☐	☐	☐
F. Eyes (external and optic)	☐	☐	☐
G. Ears (external and tympanic)	☐	☐	☐
H. Nose, Mouth, Pharynx	☐	☐	☐
I. Teeth	☐	☐	☐
J. Heart	☐	☐	☐
K. Lungs	☐	☐	☐
L. Abdomen (includes 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)	☐	☐	☐
Q. Muscular Coordination	☐	☐	☐
R. Nutrition	☐	☐	☐

S. General Statement of Child's Physical Status:

Food/Other Allergies/Asthma:

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

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 Abnormalitites on chest x-ray suggestive of TB
→Have contact w/or family hx of confirmed/suspected TB and/or HIV seropsitivity
→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 ast 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	Given Today: Still not up-to-date for age	
IPV			
Hib			
Hep B			
MMR			
Varicella			
Hep A			
PCV-13			

Medications:

Sign & Date:

CARE PROVIDER'S CLINIC STAMP