PHYSICAL EXAM

Holy Cross Head Start Inc.

WELL-CHILD HEALTH ASSESSMENT

Information on this form is considered CONFIDENTIAL and must not be disclosed without proper authority.

Please complete all sections per American Academy of Pediatrics (AAP) guidelines

Child's Name: _____ Date of Birth ____/____/____ Gender: □M □F Date of Exam ____/____/____

Allergies: □ NKA □ YES (Specify) Medications: □NO □YES (Specify) Acute or Chronic Illnesses: □NO □YES (Specify) Behavioral Concerns:	**Height:**_____ **Weight:** _____**lbs** **Blood Pressure:** _____**mm/Hg** **Head circumference (infant):** _____ **BMI:** _____

SCREENINGS AND RISK ASSESSMENT

Lead Blood Level	Date __/__/__	**Level _____mcg/dl** □ **Normal** □**Abnormal**	**Treatment needed:** □**No** □**Yes (Specify)**
Blood Count	Date __/__/__	**HGB _____g/l** **HCT____%**	**Treatment needed:** □**No** □**Yes (Specify)**
Sickle Cell Risk Screening	□Performed at Birth Date __/__/__	**Result :** □**Normal** □ **+Disease** □ **+trait**	**Treatment needed:** □**No** □**Yes (Specify)**
Vision	**Right**	**Left**	**Both**
Actual (> 3Year)	**20/_____**	**20_____**	**20/_____**
Gross(<3Year)	□**Normal** □**bnormal**	□**Normal** □**Abnormal**	□**Normal** □**Abnormal**
Referred	□**Strabismus**	□**Strabismus**	□ **Child wears Glasses**
HERARING	**RIGHT**	**LEFT**	
	□**Myringotomy Tube**	□**Myringotomy Tube**	
Acuity (> 3Year)	□**500 dB** □**1000 dB** □**2000dB** □**40000dB**	□**500 dB** □**1000 dB** □**2000dB** □**40000dB**	
Gross(<3Year)	□**Normal** □**Abnormal**	□**Normal** □**Abnormal**	

Tuberculosis (TB) Risk Assessment

□No Risk Factors
□Risk Factors Present

*Considered to be high risk for TB if the answer is yes to one or more of the following:

□ Contacts with individuals who have infectious tuberculosis
□ Children who are born outside of the United States
□ Children determined to have abnormal chest X-rays related to signs of TB
□HIV infected children
□Children with low immune systems
□Children with medical risk factors: Hodgkin's disease, Lymphoma, Diabetes Mellitus
□ Chronic Renal Failure, Malnutrition
□Children frequently exposed to adults that are HIV infected, homeless, and residents of nursing homes.
□Migrant farm workers

Assessment	Normal	Abnormal	Referred
General Appearance			
Posture, Gait			
Speech			
Head			
Skin			
Eyes External Aspect			
Optic Fundoscopic			
Cover Test			
Nose, mouth, Pharynx			
Teeth/Gums			
Heart			
Lungs			
Abdomen (include hernia)			
Genitalia			
Bones, Joints, Muscles			
Neurological/ Social			
Gross motors			
Fine motor			
Communication Skills			
Cognitive			
Self Help Skills			
Social Skills			
Glands Lymphatic/Thyroid			
Muscular Coordination			
Others			

***ATTACH CHILD'S IMMUNIZATION RECORD**

If child's not up to date, please indicate specific follow-up dates. OCFS licensing regulation418.1-11(e)(1) requires Head Start to see evidence of specific follow up appointment dates before it may allow a child to enter program. This facility requires that children who are enrolled in a group care setting have received age-appropriate preventive health services, including screening and immunization that meet the current recommendation of the American Academy of Pediatrics. This schedule is available at https://downloads.aap.org/AAP/PDF/periodicity_scheduled.pdf.

Base on information gathered during this examination, I find that this child currently appears to be free from contagious or communicable disease, is receiving health care in accordance with the AAP schedule, and is able to safely attend child day care .

Signature of Examiner _____

Print Name (or stamp)_____

Address_____

Phone #_____

Completed by (if different than Examiner) _____

Date Form Completed ____/____/____/

Revised 5/2020