Child Health Record – Head Start/Early Head Start Physical Assessment

*Send This Form To:	*Send Statement To:
York County Head Start 0-5 – P.L.A.Y.	(only if bill is **NOT** covered by Medicaid or insurance)
225 West 5th Street	Blue Valley Community Action Partnership
York, NE 68467	P.O. Box 273
Fax Number: 402-362-4310	Fairbury, NE 68352

Section 1 - To Be Completed By Parent(s)

Child's Name:	Sex:	Date of Birth:
Parent/Guardian Name:	Parent/Guardian Name:	
I give my consent for my child's Health Care Provider and the BVCA Head Start Staff to discuss the information on this form. Signature/Date:	Signature/Date:	

Section 2 – To be completed by Health Care Provider

Screening Test: Starred items (*) are ***REQUIRED*** by Head Start and are recommended by the American Academy of Pediatrics for children 0-5 years. **Enter date of last LEAD screening if done at 2 years of age or older and are WNL(<10). If there are no records of lead screening, one will need to be done. Hgb/Hct are required yearly.** When recording results, enter at a minimum "N" (Normal), "S" (Suspect), or "A" (Atypical/Abnormal).

Lab Test	Date	Results Are Required
A. ***LEAD TEST** (last test needed to be at 2 years or older and <10)		
B. ***HEMATOCRIT/HEMOGLOBIN** (Required yearly)		

PHYSICAL EXAMINATION/ASSESSMENT

***Blood Pressure** — **Immunizations are: Complete ☐ Up-to-date ☐ Recommended now ☐**

***Height** — ***Weight**

	Normal	Abnormal	Not Eval.	COMMENTS :
General Appearance				
Posture, Gait				
Speech				
Head				
Skin				
Eyes: (1) External Aspect				
(2) Optic Fundiscopic				
(3) Cover Test				
Ears: (1) External & Canals				
(2) Tympanic Membranes				
Nose, Mouth Pharynx				
Teeth				
Heart				
Lungs				
Abdomen (including hernia)				
Genitalia				
Bones, Joints, Muscles				**Abnormal Findings/Diagnosis:**
Neurological/Social:				
1. Gross Motor				
2. Fine Motor				
3. Communication Skills				
4. Cognitive				**Treatment Plan:**
5. Self-help Skills				
6. Social Skills				
Glands				
Muscular Coordination				**Recommended Follow-Up Appointment Date & Time:**
Other:				

General Statement On Child's Physical Status:

Physician's Signature ______________________________ Date________

***MANDATORY**

Upload to ChildPlus: Health