Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
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PHYSICAL SCREENING FOR CHILDREN

Child's Name _____ **Child's Date of Birth**_____
Last First

Parent Name_____ Childcare Center/FCCH_____
Last First

PHYSICAL ASSESSMENT/WELL BABY CHECK

	No Problem	Problem Suspected	Comments/Referrals
History and Physical Exam			
Nutritional Assessment			
Developmental Assessment			
Dental Assessment			**Fluoride Applied?** ☐ **Yes** ☐ **No** **If yes, date:** _____
Tobacco Assessment (exposure to second hand smoke)			
Lead Assessment			_____ **Blood Lead Level Results**
Weight			_____ **Date of Last Lead Result**

REQUIRED FOR HEAD START

Head Circumference _____ Ht._____Wt. _____

Hearing: **(circle one) R** pass / fail **L** pass / fail

Vision: **R-20/** **L-20/**

*****TB Risk Assessment ❑ at risk ❑ not at risk OR**
TB Test Date Given_____Read_____Result____

	Date Given	Date Read	Results
****Hgb/HCT**	_____	_____	_____
UA	_____	_____	_____
BP	_____	_____	_____

IMMUNIZATIONS GIVEN TODAY

DTP _____ **HepB**_____
IPV _____ **HepA** _____
MMR_____ **HIB**_____
Varicella_____ **Other**_____

MEDICAL EVALUATION: Comments / Referrals:

1. Are there any **physical or emotional conditions** (orthopedic, cardiac, eye, ear, etc.) which may affect participation in school activities?

   ☐ Yes ☐ No Explain: _____

2. **Is the child subject to any condition that may result in a classroom emergency** {e.g., epilepsy, seizures, fainting spells, diabetes, heart condition, allergic reactions (bee stings, etc.)}? ☐ Yes ☐ No

   Explain: _____

3. Is this child under your regular care? ☐ Yes ☐ No **Date of examination:** _____

Parent's Authorization: *I hereby give my consent to the Head Start agency listed above to receive or send to Dr._____, information from the above physical, to include results, or follow up health information concerning my child (for the duration of one year of signature).*

Autorización de Padres: Por la presente doy mi consentimiento a la agencia de Head Start nombrada arriba para recibir o enviar al Dr._____,información del examen físico anotado arriba, para incluir los resultados, o hacer un seguimiento de información medica relacionada con mi hijo/hija (para la duración de un ano de la firma).

Signature of Parent or Guardian

_____ *Date*_____

Firma de Padre/Tutor ***Fecha***

PHYSICIAN SIGNATURE: _____ ***Date:***_____ ***Exam Date:***_____

_____ _____

Clinic Name ***Clinic Phone Number***

Distribution: White – Health File Yellow – Parent Copy