CENTER: ____________________

LUZERNE COUNTY HEAD START: PHYSICAL EXAM AND ASSESSMENT

HEAD START CHILD: ______________________________ **D.O.B.** ______________

PHYSICIANS NAME: ______________________________ **PHONE:** ______________

ADDRESS: ____
Street

____
City State Zip

Medical History or Conditions ____

____

	NORMAL FOR AGE	ABNORMAL	REFER FOR EVALUATION	NOT EVALUATED
General Appearance	☐	☐	☐	☐
Posture, Gait	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Head	☐	☐	☐	☐
Skin	☐	☐	☐	☐
Eyes External aspects	☐	☐	☐	☐
Optic fundoscopic	☐	☐	☐	☐
Cover test	☐	☐	☐	☐
L R Visual Acuity___ ___	☐	☐	☐	☐
Ears External Canal L R ___ ___	☐	☐	☐	☐
Hearing Screening Completed	☐ Y	☐ N	Results: ________	
Nose, Mouth, Pharnyx	☐	☐	☐	☐
Teeth	☐	☐	☐	☐
Heart	☐	☐	☐	☐
Lungs	☐	☐	☐	☐
Abdomen(include hernia)	☐	☐	☐	☐
G.I./G.U.	☐	☐	☐	☐
Bones, Joint, Muscles	☐	☐	☐	☐
Neurological/Social	☐	☐	☐	☐
Motor Skills	☐	☐	☐	☐
Developmental skills	☐	☐	☐	☐
Cognitive	☐	☐	☐	☐
Other: ____________				

Please Provide date and results.
Please provide lead level results done at 12/24 months or later. If not available, please order and provide results to Head Start.

Lead ____________
H + H ____________
TB ____________
Other ____________

Immunizations Given Today:

Yearly Influenza Vaccine:

Nutritional Concerns:

Ht.______ Wt.______
BP______ BMI ______

Allergies(Drug/Foods/Other):

Please provide note for any dietary allergies/restrictions

Current Meds:____________________

Comments:____________________

SIGNATURE: ______________________________ **DATE:** ______________

9/16/2013

Actual Date of Exam: ______________

PLEASE SEE OTHER SIDE

FINDINGS, TREATMENTS, AND RECOMMENDATIONS

DATE MO. DAY YR.	
____/_____/____	Abnormal Findings/Diagnosis
____/_____/____	Treatment Plan
____/_____/____	Recommended Follow-up or Results (initial when complete)

DATE MO. DAY YR.	
____/_____/____	Abnormal Findings/Diagnosis
____/_____/____	Treatment Plan
____/_____/____	Recommended Follow-up or Results (initial when complete)

LUZERNE COUNTY HEAD START, INC.

Serving Luzerne & Wyoming Counties

CENTER: ____________________

DENTAL EXAM & TREATMENT RECORD

EARLY HEAD START/HEAD START CHILD: ________________________ **D.O.B.** ___/___/____

Dental Office Computer Print Out Accepted

EXAM

Date of Visit: ____/_____/______

Exam: □ Yes □ No

Cleaning: □ Yes □ No

Fluoride: □ Yes □ No

Does child receive daily fluoride supplementation? □ Yes □ No

Does child need treatment? □ Yes □ No

TREATMENT STATUS

Treatment needed: □ Restorations □ Pulp Therapy □ Extractions □ Other: _______________

Is this child being referred to a pediatric dentist for treatment? □ Yes □ No □ N/A

Will your office be making the treatment appointment on behalf of this child? □ Yes □ No

If yes, name of Pediatric Dentist: ____

Has treatment been initiated? □ Yes □ No

Has treatment been completed? □ Yes □ No Date Completed: ___/___/____

NEXT VISIT

Date: ___________________________________ Time: ________________________________

Purpose: □ Recall for Preventative Visit □ Treatment

Dentist Signature: _______________________________ Date: _____/_____/________

Print/Stamp: ___________________________________