Los Angeles County
Office of Education

Leading Educators ▪ Supporting Students ▪ Serving Communities

Head Start - State Preschool

PROGRAM CHILD IS ENROLLED IN		
☐ Head Start	☐ Early Head Start	
☐ Center Base	☐ Home Base	☐ FCC

Confidential Medical Record Part II
Physical Exam and Screening Tests

LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	SEX ☐ M ☐ F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN
DELEGATE AGENCY NAME/SITE			

TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE	
TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
inches (%)	lbs/oz (%) BMI for age (%)	

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Blood Pressure (age 3+)			Mouth/Teeth/ Oral Health			Genitalia		
Skin						Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Hearing (Birth to 3)		
Nose			Abdomen			Vision (Birth to 3)		

Vision Acuity (Age 3+)		Right	Left	Both
Date of Test		20/	20/	20/
Type of Test				

Hearing (Age 3+)		Frequency	Right Ear	Left Ear
Date of Test		1000 Hz	dB	dB
		2000 Hz	dB	dB
Type of Test		3000 Hz	dB	dB
		4000 Hz	dB	dB

Laboratory - Tests & Results				
DATE	HGB	HCT	DATE	LEAD
	gms	%		mcg/dl
TREATMENT			DATE OF FOLLOW-UP APPOINTMENT	

PPD - TB Screening				
DATE GIVEN	RESULTS			DATE READ
	mm	☐ Non Significant	☐ Significant	
DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE	

Diagnosis / Abnormal Findings	Treatment / Restrictions / Recommendations for School
	DATE OR AGE NEXT PHYSICAL EXAM DUE

TO BE COMPLETED BY HEAD START STAFF

SIGNATURE OF STAFF COMPLETING 1ST REVIEW	POSITION	DATE
SIGNATURE OF STAFF COMPLETING 2ND REVIEW	POSITION	DATE

HEAD START FOLLOW-UP	REFERRED FOR FOLLOW-UP TO
	☐ Nutrition ☐ MH ☐ FCP ☐ Education
	☐ Disabilities ☐ Other: ________________
	INITIALS/DATE FORM RECEIVED