Palmdale School District
Launching a lifetime of learning

Physical Exam and Screening Tests
(Per the Bright Futures Guidelines, see back of exam)

Early Childhood Education Program
975 E. Ave P-8 Palmdale, Ca 93550 Office
(661)273-4710 Fax (661) 273-1037

Health Care Provider: Please complete health assessment(s) required by recommended by the American Academy of Pediatrics schedule. Please indicate age at exam

☐ Under 1 mo. ☐ 2 mos. ☐ 4 mos. ☐ 6 mos. ☐ 9 mos. ☐ 12 mos. ☐ 15 mo. ☐ 18 mos. ☐ 30 mo. ☐ 2 yrs. ☐ 3 yrs. ☐ 4 yrs. ☐ 5 yrs.

CHILD'S INFORMATION

Child's Name:	☐ Male ☐ Female	DOB:	Site/Class #:

TO BE COMPLETED BY PARENT-AUTHORIZATION FOR RELEASE OF INFORMATION

You are authorized to release to Palmdale School District Early Childhood Education information regarding this health care visit for the above named child including diagnosis and treatment.

Name of Parent or Guardian:_____

Parent Signature:_____ Date:_____

Type of Health Coverage (if none please indicate):_____

To be completed by Health Provider

DATE OF EXAM:

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)

TELEPHONE NUMBER

STAMP OF CLINIC

ADDRESS (NUMBER, STREET, CITY, STATE, AND ZIP CODE _____ PROVIDER SIGNATURE _____ DATE _____

EXAMINATION RESULTS

Height Inches (%)	Weight Lbs/oz (%)	BMI for age (%)	Head Circumference (0-18mo)	Blood Pressure NORMAL ABNORMAL ____/____mmHG

ANTICIPATORY GUIDANCE SECTION, PLEASE FILL OUT EACH BOX IN THIS SECTION

EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL
Blood Pressure			Abdomen			Extremities		
Skin			Lungs/Chest			*Behavioral Assessment*		
Head/Neck			Heart			*Development Assessment*		
Lymph Nodes			Back			*Nutritional Assessment*		
Eyes			Genitalia			Lead Assessment		
Ears			*Oral Health/Dental Assessment*			*Autism Screening (18 & 24mos. ONLY)*		
Nose			*Hemoglobin Risk Assessment*					
Throat								

VISION & HEARING SCREENINGS

VISION Screening (Age 0-2yrs)	HEARING Screening (Age 0-2yrs)	VISION ACUITY TEST (Age 3-5)			
Vision (Clinical Observation)	Hearing (Clinical Observation)	Date of Test	Right	Left	Both
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	Type of Test	20/	20/	20/

LABORATORY- TEST & RESULTS

HEMOGLOBIN		LEAD	
Date	Hgb/Hct gms/%	Date	Mcg/dl

HEARING AUDIOMETRIC (Age 3-5)		Right Ear	Left Ear
Date of Test	1000 Hz	dcb	dcb
	2000 Hz	dcb	dcb
Type of Test	3000 Hz	dcb	dcb
	4000 Hz	dcb	dcb

New Born Blood Test Date Performed: ☐ Normal ☐Abnormal

DIAGNOSIS/ABNORMAL FINDINGS

☐ Underweight ☐ Overweight ☐ Obese ☐ Asthma

☐ Dental Referral ☐ Anemia ☐ Allergies: _____

☐ Outstanding Medical Conditions: _____

SCREENING OF TB RISK FACTORS

☐ Risk factors not present; TB test not required

☐ Risk factor present; Mantoux TB skin test performed. (Unless previous positive skin test documented).

☐ Communicable TB disease not present.

PPD Date Given:	Date Read:	PPD Results:

TREATMENT/RESTRICTIONS/RECOMMENDATIONS FOR SCHOOL

TO BE COMPLETED BY HEAD START STAFF

HEAD START FOLLOW-UP

Signature of Staff Completing Review	Position	Date Reviewed

REFERRED FOR FOLLOW-UP TO: Nutrition MH FCP Education Health Disabilities — Date/Initials when received:

PLEASE FILL OUT THIS EXAM IN ITS ENTIRETY TO COUNT AS A COMPLETE PHYSICAL FOR THE EARLY CHILDHOOD PROGRAM