Please Return Completed Form (or a copy of the physical form used by the physician) to:
The Early Childhood Office
915 East 1st Street, McPherson KS 67460
Telephone: 620-241-9590 Fax: 620-241-9565

CHILD HEALTH ASSESSMENT

Child's Name:_______________________________________ Birth Date:___________________

Parent/Guardian:____________________________________ Phone:______________________

SCREENING RESULTS (Please indicate dates of screenings)

Height:________________ Weight:______________ Blood Pressure:________________

Hearing: Right ___________ Vision: Right___________ Hgb or Hct:_________________

Left____________ Left____________ Blood Lead:_________________
(If not done at 24 months)

Both___________

Physical Examination: To be completed by physician or nurse approved to do health assessment.

	Normal	Above	Not Evaluated	Comments
General Appearance				
Posture, Gait				
Head				
Skin				
Eyes: External Aspects				
Optic Fundoscopic				
Ears: External & Canals				
Tympanic Membranes				
Nose, Mouth, Pharynx				
Teeth				
Heart				
Lungs				
Abdomen				
Genito-Urinary				
Musculoskeletal				
Neurological/Social				
Gross Motor				
Fine Motor				
Communication Skills				
Cognitive				
Self-Help Skills				
Social Skills				
Lymphatic				
Other				

General Statement on Child's Physical Status:

Significant Assessment Findings/Recommendations:

____

Examiner's Signature Exam Date.