MARC: HEALTH RECORD (3 thru 5 YEARS)

Head Start
MID-AMERICA REGIONAL COUNCIL

NAME: _____ **DOB:** _____ **SEX:** ____ **AGE:** ____
RACE/ETHNICITY: _____ **DATE of EXAM:** _____

FAMILY PROFILE AND HEALTH ___ No change in household since last visit
Child lives with: ____Mother ____Father ____Stepparent ___Grandparent ___Other Total adults living in home: ____
Total children living in home: ____ Primary caretaker for this child: _____ Relationship: _____
Family's concerns/problems:

NUTRITION *Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental __Y __N
Usual Servings Per Day: ___Dairy __Vegetables WIC _Y _N
__Breads, cereal, rice and pasta ___Meat, poultry, fish, eggs and dry beans ___Fruits
Fluoride: __Y __N Supplement: __Y __N
*If answered yes, further assessment needed

DEVELOPMENT Parent's concerns

3 YEARS	**4 YEARS**	**5 YEARS**	
_Brushes teeth with help	_Puts on T-shirt	_Brush teeth-no help	Standardized screen: __P __F __Not Done
_Tower of 6 cups	_Wiggles thumb	_Copies	Further assessment needed: __Yes __ No
_Uses pronouns, I, you, me	_Expresses needs, ideas in 3-6 word sentence	_Carries on a conversation	**Vision Screen: __Normal __Abnormal**
			Hearing Screen: __Normal __Abnormal
_Throws ball overhand	_Balances on 1 foot, 2 sec	_Balances on 1 foot, 3 sec	

CHILD HEALTH: Does the systems review note any problems or parent concerns: __Yes ___No Explain:
Major illnesses, injury hospitalization, surgery (since last visit):

Allergies:
Medication taken regularly, Type/Reason:
Dental Care:
Mental Health/Behavioral Concerns:

PHYSICAL EXAMINATION

HGB/HCT_____ **LEAD**_____
BP _____ **Height**_____ **Weight** _____
(%) _____ (%) _____
Temp _____ Pulse _____ Resp _____

N	A	NE	
☐	☐	☐	Appearance
☐	☐	☐	Head
☐	☐	☐	Skin/nodes
☐	☐	☐	Eyes
☐	☐	☐	Ears
☐	☐	☐	Nose
☐	☐	☐	Mouth/throat
☐	☐	☐	Teeth
☐	☐	☐	Neck
☐	☐	☐	Chest/breasts
☐	☐	☐	Heart/pulses
☐	☐	☐	Lungs
☐	☐	☐	Abdomen
☐	☐	☐	Genitalia/Anus
☐	☐	☐	Spine
☐	☐	☐	Extremities
Neurologic			
☐	☐	☐	Muscle tone
☐	☐	☐	DTRs

HEALTH EDUCATION

INJURY PREVENTION
__Car safety restraints
__Poisoning
__Fire Safety
__Firearms
__Street, water, bicycle Safety
__Scissors/Sharp objects
__Stranger safety
__Teach telephone Number and address
__Self-safety
__Passive smoking

BEHAVIOR
__Talk/read with child
__Exploration
__Limit television
__Discipline, consistency
__Toilet training
__Social interaction
__School readiness
__Sex education

HEALTH PROBLEMS
__Immunizations
__Well child care
__Dental care, appt.
__Family planning
__Daycare

NUTRITION
__Health diet/snacks
__Junk Food
__Iron rich foods
__Physical activity

ASSESSMENT:

PLAN

Dental referral made: __Yes __No
WIC: ___Referral ___Refused __N/A
Immunizations: __Up to date __To be given today ___Deferred
Explain:

Next appointment:

Current State of Health: I have examined the above-named child and verify that this child's medical history and current state of health ___are ____are not satisfactory for participation in a childcare program. Does this child require any specialized care? ___Yes ____No
If yes, please explain:

Name and Address of Clinic, Group, Practice or other_____

Telephone Number_____ Fax Number_____

Physician Signature _____Date _____ Physician Name (Print)_____
(This form expires one year from date of exam.) Form 1070 Revised 3/14/14