HEALTH ASSESSMENT FOR CHILDREN & YOUTH

CONFIDENTIAL: Child Health Record (To be released only on signature of parent/guardian)

STATEMENT OF CONSENT

In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to school and other appropriate health professionals.

Parent or Guardian: ______________________ Date:

Name: ______________________ Birth Date: __________ Male/Female *(Circle One)*

Address: ______________________ City: __________ Zip __________

Parent/ Guardian: ______________________ Phone/Work: __________ Home: __________

Child lives with: ______________________ Phone/Work: __________ Home: __________

Physician ______________________ Date of last exam: __________

Dentist ______________________ Date of last exam: __________

Eye Doctor ______________________ Date of last exam: __________

School: ______________________ Community Services: __________

Family Health History

Response Codes: M=Maternal P=Paternal S=Sibling NA=Not Applicable

	Question	Code	Comment
1.	Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, or others? Comment?	____	________
2.	Does any family member have a vision defect, hearing loss, or spinal deformity? Comment?	____	________

Child/Adolescent History

	Question	Code	Comment
1.	Birth weight: ________. Where there any pre-natal or delivery problems with the child?	____	________
2.	Did this child walk, talk, and develop at the usual time?	____	________
3	Does this child/adolescent:	____	________
a.	See a health care provider regularly?	____	________
b.	Use any medication, drugs, or alcohol?	____	________
c.	Have a history of hospitalizations, surgeries, or emergency room visits?	____	________
d.	Have a history of any childhood diseases/illnesses?	____	________
e.	Have a history of other communicable diseases?	____	________
f.	Age of menarche ________. Have a history of menstrual problems?	____	________
g.	Have a history of vision, speech, hearing, or communication problems?	____	________
h.	Have a problem with being tired or overactive?	____	________
i.	Have any emotional or behavioral problems?	____	________
j.	Need any special help in school or day care?	____	________
k.	Have sexuality concerns?	____	________
l.	Have any chronic illness or disabling problems with *(check those that apply)*:	____	________

____ Headache ____ Convulsions ____ Diabetes ____ Earaches ____ Back/spine/extremity problems

____ Cold/sore throat ____ Rheumatic fever ____ Allergies/asthma ____ Genitalia Oral/dental

____ Heart/lung disease ____ Digestive ____ Urinary/bowel ____ Other ________

List present concerns of child/parent/guardian:

PHYSICAL EXAMINATION: *To be completed by health care provider approved to perform health assessments*

Height: ____________ Weight: ____________ Hgb or Hct: ____________
Pulse: ____________ Blood Pressure: ____________ Lead: ____________
Urinalysis: ____________ Sickle Cell: ____________ Other: ____________
Tuberculosis: ____________ Head Circumference: ____________

Code each item as follows: 0= No significant findings 1=Significant findings	Code	Comments / Description of Findings
General Appearance		
Integument		
Head – neck		
EENT		
Oral – dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

Nutrition/WIC questionnaires available from 785-296-0092.

1. Nutritional Evaluation
   (all ages – each screen) (circle if applicable).
   Enrolled in WIC   Receiving vitamin supplement with iron   Without iron   Fluoride supplement
   Food intake review. Results:
   Milk/milk products (breast fed/type of formula) ____________
   Fruit/vegetables ____________
   Meat, beans, eggs ____________
   Breads, cereals ____________
2. Development: *Type of screen:* ____________ *Results:* ____________
3. Speech: *Type of screen:* ____________ *Results:* ____________
4. Hearing: *Type of screen:* ____________ *Results:* ____________ Date last screen: ____________
5. Vision: *Type of screen:* ____________ *Results:* ____________ Date last screen: ____________

Significant assessment findings:
Recommendations (include referrals):
Follow Up:

Anticipatory Guidance (circle those discussed)

1. Safety/poisons 2. Nutrition 3. Parenting 4. Family Planning 5. Discipline 6. Immunizations 7. Hygiene
8. Lifestyle 9. Development 10. Behavior 11. Sexuality 12. Dental 13. Other

Additional information may be attached.

______________________________ ____________
Signature of physician/nurse approved to perform health assessments   Date