

HEALTH ASSESSMENT FORM FOR COMPLIANCE
WITH K.S.A. 72-5214 (Health Assessment at School Entry)

I hereby consent for my child, _____,
to receive a health assessment screening. I understand that this screening includes:
hearing, vision, dental, lead, urinalysis, hemoglobin/hematocrit, nutrition,
developmental, health history, and a complete physical examination.

**If the HEALTH ASSESSMENT FOR CHILDREN AND YOUTH form is
used for school entry, a copy should accompany the student to school.**

Parent/guardian

Date

Do not write below this line

I certify that _____ has completed the health assessment screening
Child's name
required by Kansas law.

Health Care Provider

Date

Complete and attach this section only if parent refuses to sign consent on Health Assessment form for Children and Youth.

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

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: _____

Address: _____

City: _____

Zip: _____

Parent/Guardian: _____

Phone/Work: _____ Home: _____

Child lives with: _____

Phone/Work: _____ Home: _____

Number in household: _____

Type of family housing: _____

Physician: _____

Date of last examination: _____

Dentist: _____

Date of last examination: _____

Eye Doctor: _____

Date of last examination: _____

School: _____

Community Services: _____

FAMILY HEALTH HISTORY

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

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

Response Codes: Y = Yes N = No NA = Not applicable.

Code

Comment

1. Birth weight _____. Were 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 any 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 _____	Ear aches _____	Back/spine/extremity problems _____
Cold/sore throat _____	Rheumatic fever _____	Genitalia _____	Oral/dental _____	_____
Heart/lung disease _____	Allergies/asthma _____	Digestive _____	Urinary/bowel _____	Other: _____

List present concerns of child/parent/guardian:

Immunization: Record **date** of each dose received (mm/dd/yy)

	1 st	2 nd	3 rd	4 th	5 th	6 th		1 st	2 nd	3 rd
DPT							MMR			
Td/DT							HBV			
OPV or IPV										
HIB										

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

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

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

SCREENING

1. Nutritional evaluation (all ages - each screen) (/ if applicable). Nutrition/WIC questionnaires available from 785-296-0092.
“ 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:

Additional information may be attached

Anticipatory Guidance (circle those discussed)

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

Comments:

Date

Signature of physician or nurse approved to perform health assessments