HEALTH ASSESSMENT FOR CHILDREN AND YOUTH - **page 1 by parents, page 2 by physician**

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

Parents fill this page out → _____ _____
Electronic Signature Parent / Guardian

Name: _____ Birthdate: _____ Male/Female: _____
Address: _____ City: _____ ZIP CODE: _____
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: _____

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 of spinal deformity? Comment?		

CHILD/ADOLESCENT HISTORY

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

1.	Birthweight_____ 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 any history of childhood diseases/illnesses?		
e.	Have a history of communicable diseases?		
f.	Age menarche? _____ Have a history of menstrual problems?		
g.	Have a history of vision, speech, hearing or communications 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:		

_____Headaches _____Convulsions _____Digestive disorders _____Colds/sore throats

_____Rheumatic fever _____Earaches _____Heart/lung disease _____Allergies/asthma

_____Back/spine problems _____ Diabetes _____Urinary/bowel problems _____Extremity problems

_____Oral/dental problems _____Genitalia _____ Other _____**None of the above**

Parents, please explain any of the above that you listed as a "yes". List any present concerns that you might have:

_____

_____

_____

_____

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

Height: _____ Weight: _____ Hbg/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**	**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)*
   *Nutrition/WIC Questionnaires available from (913) 296-0092
   Is Child: (Response Codes: Y = Yes N = No NA = Not applicable)

   a. Enrolled in WIC _____

   b. Breastfed _____

   c. Formula-Fed _____

   Type: _____

   d. Receiving Vitamin Supplement with iron _____ Without iron _____

   e. Receiving Fluoride Supplement _____

   f. General Nutrition Status _____

2. Development: Type of screen _____ Results_____
3. Speech: Type of screen_____ Results_____
4. Hearing: Type of screen_____ Results_____ Date of last screen: _____
5. Vision: Type of screen_____ Results_____ Date of last screen: _____

Significant Assessment Finding:

_____

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

Comments:

_____**Phone #**_____

Date **Signature of Licensed Physician or Nurse approved to perform health assessments.**