Confidential Child Health Record (To be released only on signature of parent/guardian.)

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/Guardian Signature _____ Date _____

Name: _____ Birthdate: _____ 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: _____

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

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 a history of any childhood diseases/illnesses?
   e. Have a history of other communicable diseases?
   f. Age 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:

Headaches	_____	Convulsions	_____	Digestive	_____
Colds/sore throat	_____	Rheumatic fever	_____	Earaches	_____
Heart/lung disease	_____	Allergies/asthma	_____	Oral/dental	_____
Back/spine	_____	Diabetes	_____	Urinary/bowel	_____
Extremity problems		Genitalia	_____	Other	_____

List present concerns of child/parent/guardian:

Immunization	**Record date of each dose received (mm/dd/yy**						
	1st	2nd	3rd	4th	5th	6th	7th
DPT (Diphtheria, pertassis, Tetanus) &/or Td/DT	/ /	/ /	/ /	/ /	/ /	/ /	/ /
OPV or IPV (Polio)	/ /	/ /	/ /	/ /	/ /	/ /	/ /
MMR (Measles,Mumps,Rubella)	/ /	/ /	/ /	/ /	/ /	/ /	/ /
HBV (Hepatitis B)	/ /	/ /	/ /	/ /	/ /	/ /	/ /
HIB (Haornophilius influenza B)	/ /	/ /	/ /	/ /	/ /	/ /	/ /

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

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

Code Each Item as Follows: O = No significant findings I = 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 ____ d. Receiving Vitamin Supplement with Iron ____ Without Iron ____
   b. Breastfed ____ e. Receiving Fluoride Supplement ____
   c. Formula-fed ____ f. General Nutritional Status _____
   Type _____ _____
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 Findings:

Recommendations: (include referrals)

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:

Follow Up:

_____ _____

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

This information is to be retained by the school

HEALTH SERVICES, USD #489
Hays, KS 67601
623-2607

SCHOOL_____
Grade_____
Teacher _____

HEALTH ENROLLMENT FORM
STATEMENT OF IMMUNIZATION AND HEALTH ASSESSMENT COMPLIANCE

Name of Student_____ Birthdate_____
Last First Middle Name Mo. Day Yr.

Male _____ Female _____ Age ____ Place of Birth _____
City State

Address _____ City _____ State _____

School attended prior to today's enrollment _____
School City Grade

Has student previously attended a Hays school? Yes ___ No ___ School _____

Has student previously enrolled in any other Kansas school? Yes _____ No _____

School _____ City_____ Grade _____

NOTE: If medication, either prescription or over-the-counter, is to be taken at school, it must be brought to school in the original container. A parent or guardian must complete and sign a permission form. Please contact your school nurse for specific directions.

* *

I hereby certify that any Health Assessment and/or additional immunizations needed to complete school entry requirements will be received by this child. I understand that failure to comply shall result in exclusion from school until necessary requirements are completed and documentation is provided to the school.

I give my consent for immunization information to be shared with the Kansas Immunization Program and my child's health care provider for the purpose of assessment and reporting to prevent diseases.

Signed _____ Date _____
Parent/Guardian Mo. Day Yr.

☺ ☺ ☺ **over** ☺ ☺ ☺

For important health update information.

4-10

Please fold, staple & return directly to the school nurse

ANNUAL HEALTH UPDATE

Student Name: _____ **Grade:**____ **School:**_____ **Birthdate** _____

Student Health Insurance: Private Insurance Medical Card Healthwave No Insurance
(Please Circle one)

Circle Yes or No. **Please explain all "YES" answers and give "Date".**

Yes No **ADD/ADHD**
Medication and Dose: _____
Yes No **Allergies** _____
Yes No **Asthma.** Diagnosed by physician? Yes___ No___ Age _____
Medication: _____
Yes No **Diabetes**
Initial diagnosis at age _____
Yes No **Emotional/Behavioral Concerns** _____
Medication: _____
Counseling: Yes____ No____
Yes No **Fainting or sudden loss of consciousness**
Please explain _____
Yes No **Frequent Ear, Sinus, or Throat Infections** _____
Yes No **Frequent Headaches.** If Migraine, diagnosed by physician? Yes __ No __ Age __
Medication: _____
Yes No **History of Head Injuries or Major Accidents of any kind** _____
_____
Yes No **Heart, Blood Disease or High Blood Pressure** _____
Yes No **Seizure Disorder:** Initial diagnosis at age _____
Type of Seizure: _____
Medication: _____
Yes No **Urinary/Bowel Condition** _____
Yes No **Hearing Problem/Loss** _____
Yes No **Vision :- Last exam by eye doctor** _____(date).
Circle One: No correction Glasses Contacts Wears always Wears sometimes
Eye Surgery or other visual problems: _____
Yes No **Other Health Concerns:** (surgeries, hospitalizations, injuries, etc.) _____
_____
Yes No **Daily Medication:** (not listed above) _____
_____
Yes No **Any Other Medications:** _____
Yes No **Is there anything you would like to discuss with the school nurse?** _____
_____

I agree that this health information may be shared with appropriate staff.

Signature_____ **Date**_____

8-08

School Dental Health Card
USD 489 Health Services (Tarjeta de Salud Dental Escolar)

Pupil's Name: _____ Age: _____ Grade: _____

School: _____ City: _____

To pupils and parents: The purpose of requesting each pupil to have his/her teeth examined by the dentist at least once each year, or more often if the dentist so advises, is to discover dental defects and infection, if present, in the beginning. By doing this, treatment can be given with the least amount of discomfort to the pupil and at the lowest cost to the parent. Pain, sickness, and unnecessary loss of teeth resulting from dental diseases are thereby also prevented. You are therefore urged to take this card to your family dentist and have any necessary dental work done as soon as possible. When the dentist has signed the card, please return it to the school.

Date: _____ School Nurse: _____

_____ A. I have examined the teeth of the above pupil and find no fillings, extractions, or cleaning needed.

_____ B. I have completed the necessary dental work for this pupil.

Date: _____ DDS: _____

Doctor: Do not sign this card unless necessary work is actually completed.