Circle USD 375
District Office 316-541-2577
District Fax 316-536-2249
Confidential Child Health Record (To be released on signature of parent/guardian.) 4/13

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 _____ State _____
_____ Zip Code _____
Parent/Guardian _____ Mom Phone/Work _____ Home _____
Child lives with _____ Dad 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?	_____	_____
2. Does any family member have a vision defect, hearing loss, or spinal deformity?	_____	_____

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:		
See a health care provider regularly?	_____	_____
Use any medications, drugs, or alcohol?	_____	_____
Have a history of any hospitalizations, surgeries or emergency room visits?	_____	_____
Have a history of any childhood diseases/illnesses?	_____	_____
Have a history of other communicable diseases?	_____	_____
Age of menarche _____. Have a history of menstrual problems?	_____	_____
Have a history of vision, speech, hearing or communication problems?	_____	_____
Have a problem with being tired or overactive?	_____	_____
Have any emotional or behavioral problems?	_____	_____
Need any special help in school or day care?	_____	_____
Have sexuality concerns?	_____	_____

Have any chronic illness or disabling problems with (check those that apply):

Headache _____ Convulsions _____ Diabetes _____ Ear Aches _____ Cold/Sore Throat _____
Back/Spine/Extremity problems _____ Rheumatic Fever _____ Genitalia _____ Oral/Dental _____
Heart/Lung Disease _____ Allergies/Asthma _____ Digestive _____ Urinary/Bowel _____
Other _____

List present concerns of child/parent/guardian:

COPY OF ORIGINAL IMMUNIZATION RECORD NEEDS TO BE ATTACHED

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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**	**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) (check 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 _____

1. Development: Type of screen _____ Results: _____
2. Speech: Type of screen _____ Results: _____
3. Hearing: Type of screen _____ Results: _____Date Last Screen:_____
4. Vision: Type of screen _____ Results: _____Color: _____ Date Last Screen:_____

Significant assessment findings:

Recommendations (includes 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:

_____
Signature of physician or nurse approved to perform health assessments

_____
Date

Additional information may be attached.

Kansas Department of Health and Environment, Bureau for Children, Youth & Families. 12/92 Posted July 2000