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 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

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 other?		
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

Question	Code	Comment
1. Birth weight ______ Were there any pre-natal or delivery problems?		
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, alcohol?		
c. Have a history of any hospitalization, surgeries?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Have a history of vision, speech, hearing problems?		
g. Have a problem with being tired or overactive?		
h. Have any emotional or behavioral problems?		
i. Need any special help in school or day care?		

j. Have any chronic illness or disabling problems with:

Headache ____ Convulsions ____ Diabetes ____ Earaches ____
Colds/sore throat ____ Rheumatic fever ____ Genitalia ____ Oral/dental ____
Heart/lunch disease ____ Allergies/asthma ____ Digestive ____ Urinary/bowel ____
Back/Spine/extremity problems ____ Other ____

List present concerns of child/parent/guardian:

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	______				

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		

Significant Assessment Findings:

Recommendations:(include referrals)

Follow Up:

Please attach any additional Information and immunization records.

______________________ Date

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