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

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: _____
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. 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:		

Headache ___ Convulsions ___ Diabetes ___ Earaches ___ Back/spine/
Colds/sore throat ___ Rheumatic fever ___ Genitalia ___ Oral/dental ___ extremity problems ___
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)

	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DPT (Diphtheria, pertussis, tetanus)							MMR (Measles, Mumps, Rubella)			
Td/DT							HBV (Hepatitis B)			
OPV or IPV (Polio)										
HIB (Hemophilus influenza B)										

see back side of page

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) (✓ if applicable) Nutrition/WIC Questionnaires available from (913) 296-0092.
   ☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement
   Food intake review. Results:
   milk/milk products (breastfed/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 of last screen _____
5. Vision: Type of screen _____ Results _____ Date of last screen _____

Significant Assessment Findings:

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:

Additional Information may be attached

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

USD 239 SCHOOLS
PERMISSION FOR MEDICATION

Name of Student: _____

School: _____ Grade: _____

Medication: _____

Dosage: _____

Date Medication Started: _____

Time of day medication to be given: _____

Date: _____ _____
Signature of Physician

I hereby give my permission for _____ to take the above prescription at school as ordered: I also understand that it is my responsibility to furnish the medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student as a result of administering such drug.

Date: _____ _____
Signature of Parent/Guardian

Approved by:

Date of Approval: _____ _____
Principal or School Nurse

(Rev. 96-97)

USD 239 SCHOOLS
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Date: _____ _____
Signature of Parent/Guardian

Approved by:

Date of Approval: _____ _____
Principal or School Nurse

(Rev. 96-97)

Tammy Schmidt, RN, BSN
School Health Nurse
USD #239 North Ottawa County
716 E. 7th Street, PO Box 247
Minneapolis, KS 67467

INHALER
ASTHMA MEDICATION
SELF-ADMINISTRATION CONTRACT

This contract, when signed by all parties, allows the student to carry and self-administer their own inhaler asthma medication. They must follow the prescribed dosage, administration time and route. They will never share their medication with another student. The medication will be kept in the student's locker, in a book bag or in a pocket when being transported to and from school and school related activities. The school will have no way of documenting the administration of medication so parents and students will need to communicate this to each other, if necessary.

Please, PUT YOUR NAME ON YOUR MEDICATION!!!!!!!!!!

Any violation of this contract will revoke this privilege and all medications will be administered under the medication policy in the office.

Student _____ Grade _____
Reason for Rx _____
Medication _____
Dosage _____ Time _____
Date Started _____ Date to Stop _____
Adverse reactions to report to prescribing physician or school nurse _____
_____
_____

Signatures:

1. Physician _____ Date _____
2. Parent _____ Date _____
3. Student _____ Date _____
4. School Nurse _____ Date _____

Medical Statement to Request School Meal Modification

Important! School Food Authorities are required to make substitutions to meals for children with a disability that restricts the child's diet on a case-by-case basis and only when supported by a written statement from a State licensed healthcare professional. If you have questions about this form, the school contact named in Part A below will assist you.

Modifications to Accommodate a Disability: A school is required to make meal modifications prescribed by a medical authority to accommodate a student's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

Part A. Student, Parent/Guardian & School Contact Information – To be completed by a parent/guardian or school contact person.

Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
School Contact's Name:	School Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the child's physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date: