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

	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:		

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 l = 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:

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:

Recommendations: (include referrals)

Follow Up:

_____ _____

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