Blue Valley Randolph/Olsburg
USD #384

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:

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)

☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement

Nutrition/WIC Questionnaires available from (913) 296-0092.

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.