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 prenatal 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 hospitalization, 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/sorethroat ____	Rheumatic fever ____	Genitalia ____	Oral/dental ____	Extremity problems ____
Heart/lung disease____	Allergies/asthma ____	Digestive ____	Urinary/bowel ____	Other ____

List present concerns of child/parent/guardian:

OVER

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments

Height	______	Weight	______	Hgb of 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) Nutrition/WIC Questionnaires available from (785) 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:

Additional Information may be attached.

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:

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