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 or guardian Date

Name: _____ Birth date: _____ 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. Birth weight _____. 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 of 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 (check those that apply):		

Headache _____ Convulsions _____ Diabetes _____ Ear aches _____ Back/spine/extremity problems

Cold/sore throat _____ Rheumatic fever _____ Genitalia _____ Oral/dental _____ _____

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							MMR			
Td/DT							HBV			
OPV or IPV										
HIB										

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 785-296-0092.
   - • Enrolled in WIC • Receiving vitamin supplement with iron • Without iron • Fluoride supplement

   Food intake review. Results:
   milk/milk products (breast fed/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 last screen: _____
5. Vision: Type of screen _____ Results:_____ Date 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 physician or nurse approved to perform health assessments