This side to be completed by parent/guardian
The backside is to be completed by approved health care provider

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Physical exams are required for all new students to Kansas schools and students entering Kindergarten,

Name: ______ Birthdate: ______ Male/Female: ______

Address: ______ City: ______ Zip: ______

Parent/Guardian: ______ Phone: Work: ______ Home: ______

Child lives with: ______ Phone: Work: ______ Home: ______

Number in household: ______ Eye Doctor: ______

Physician: ______ Dentist: ______

FAMILY HEALTH HISTORY TO BE COMPLETED BY PARENT/GUARDIAN

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. Did 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?		

l. Have any chronic illness or disabling problems with:

Headache: ______ Convulsions: ______ Diabetes: ______ Earaches: ______ Back/spine: ______ Colds/sore throat: ______

Asthma: ______ Oral/dental: ______ Allergies: ______ Digestive: ______ Extremity problems: ______

Urinary/bowel: ______ Heart/lung disease : ______ Other: ______

PLEASE DESCRIBE ABOVE PROBLEMS AND ANY OTHER HEALTH CONCERNS. ______

PLEASE LIST CURRENT MEDICATIONS. ______

This side to be completed by physician/approved healthcare provider

Name ______________________________

Immunization: Record date of each dose received (mm/dd/yy)										
	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DTaP (Diphtheria, pertussis, tetnus)							MMR (Measles, Mumps, Rubella)			
Td/DT/Tdap							Hep B (Hepatitis B)			
OPV or IPV (Polio)							Varicella (Chicken Pox)			
HIB (Hemophilus influenza B)							Hep A			

The above immunizations have been verified by the following: ______________________________

Signature of physician or other qualified person

PHYSICAL EXAMINATION: TO BE COMPLETED BY APPROVED HEALTH CARE PROVIDER.

Height ________ Weight ________ Hgb or Het ________

Pulse ________ Blood Pressure ________ Lead ________

Urinalysis ________ Sickle Cell ________ TB ________

Code Each Item as Follows: 0=No sig. findings 1=Significant findings	Code	Description of Findings
General Appearnace		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional Evaluation - Results ______________________________
2. Development: Type of screen ________ Results ______________________________
3. Speech: Type of screen ________ Results ______________________________
4. Hearing: Type of screen ________ Results ________ Date of last screen ________
5. Visioin: Type of screen ________ Results ________ Date of last screen ________

Significant Assessment Findings:

Recommendations: (to parents, teachers -- include any referrals)

Follow Up:

Anticipatory Guidance: (circle those discussed)

1. Safety
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
12. Dental
13. Other

Comments:

RECOMMENDATIONS FOR PHYSICAL EDUCATION:

Full program ________ Restricted (explain) ______________________________

No participation (explain) ______________________________

Additional Information may be attached.

________ Date ______________________________ Signature of Physician or Nurse approved to perform health assessments

Medication may be given at school only with a signed physician order and brought to school in the original container.