HEALTH ASSESSMENT FORM
FOR COMPLIANCE WITH K.S.A. 72-5214
(Health Assessment at School Entry)

I hereby consent for my child, _____

to receive a health assessment screening. I understand that this screening includes: hearing, vision, dental, lead, urinalysis, hemoglobin/hematocrit, nutrition, developmental, health history, and a complete physical examination.

If the HEALTH ASSESSMENT FOR CHILDREN AND YOUTH form is used for school entry, a copy should accompany the student to school.

_____
Parent/Guardian

_____
Date

Do not write below this line

I certify that _____ has completed the
Child's Name

health assessment required by Kansas Law.

_____
Health Care Provider

_____
Date

Complete and attach this section only if parent refuses to sign consent on Health Assessment for Children and Youth.

Confidential Child Health Record (To be released 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 _____ State _____
_____ Zip Code _____
Parent/Guardian _____ Mom Phone/Work _____ Home _____
Child lives with _____ Dad 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?	_____	_____
2. Does any family member have a vision defect, hearing loss, or spinal deformity?	_____	_____

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 medications, 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 _____ Cold/Sore Throat _____
Back/Spine/Extremity problems _____ Rheumatic Fever _____ Genitalia _____ Oral/Dental _____
Heart/Lung Disease _____ Allergies/Asthma _____ Digestive _____ Urinary/Bowel _____
Other _____

List present concerns of child/parent/guardian:

COPY OF ORIGINAL IMMUNIZATION RECORD NEEDS TO BE ATTACHED

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) (check if applicable).
   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:

_____
Signature of physician or nurse approved to perform health assessments

_____
Date

Additional information may be attached.