CHILD HEALTH ASSESSMENT

Name:_____ Birthdate:_____
Address:_____ Birthplace:_____
Parent/Guardian:_____ Birth Certificate Number:_____
Address:_____ Phone: Work_____ Home_____

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 Signature_____ Date_____

HEALTH HISTORY: To be filled out by parent or guardian

	Yes	No
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions or others?	___	___
2. Does any member of the family have a visual defect, hearing loss, or spinal deformity?	___	___
3. Were there any pre-natal or delivery problems with the child?	___	___
4. Did this child walk, talk, and speak at the usual time?	___	___
5. Does this child:		
a. See a physician regularly for any illness problem?	___	___
b. Take any medication regularly?	___	___
c. Have a history of any hospitalization?	___	___
d. Have a history of menstrual problems? (if applicable)	___	___
e. Have a history of any childhood diseases?	___	___
f. Have a problem with vision, speech or hearing?	___	___
g. Have a problem with being shy or overactive?	___	___
h. Have any emotional problems?	___	___
i. Have any chronic illness or handicaps such as:		

	Yes	No		Yes	No		Yes	No
Headaches	___	___	Convulsions	___	___	Earaches	___	___
Colds/sore throat	___	___	Rheumatic Fever	___	___	Dental	___	___
Heart/Lung Disease	___	___	Allergies/Asthma	___	___	Urinary/Bowel	___	___
Back/Spine	___	___	Diabetes	___	___	Other	___	___

PHYSICAL EXAMINATION: To be completed by physician or nurse approved to do health assessments

Height:_____ Weight:_____

Head_____ Lungs:_____ CNS:_____
EENT:_____ Breast:_____ Skin:_____
Dental:_____ Abdomen:_____ Lymphatic:_____
Cardiovascular_____ G.U.:_____ Musculoskeletal:_____

Screening Results:

Development (type of test)_____ Pulse_____
Hearing Blood Pressure_____
Right_____ Left_____ Hgb/HCT_____
Vision Urinalysis_____
Right_____ Left_____ Sickle Cell_____
Speech_____ Other_____

Significant Assessment Findings:

Recommendations: (include any special school needs)

Do you see this child for regular health supervision? Yes____ No____

Date:_____ Signed:_____Licensed Physician