HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Name_________________________________ Birthdate______________ Male/Female____________

Address_______________________________ City__________________Zip____________________

Parent/Guardian_________________________ Phone(W)______________(H)___________________

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

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		

Significant Assessment Findings:

Recommendations: **(Include referrals)**

Additional information may be attached

_______________ ____**MD, DO, RPA, ARNP, or RN**

Date **Signature** of Licensed Physician, RPA, ARNP or RN certified by KDHE to perform health assessments

____**MD, DO, RPA, ARNP, or RN**

Print Name of Licensed Physician, RPA, ARNP or RN certified by KDHE to perform health assessments