HEALTH ASSESSMENT FOR CHILDREN AND YOUTH
MUST BE TAKEN TO A PHYSICIAN

Physical exam are required for all new students to Kansas schools, and students entering the 6th and 9th grades.

Name:_____ Birth date:_____ Male/Female:_____

Address:_____ City:_____ Zip:_____

Parent/Guardian:_____ Work Phone:_____ Home Phone: _____

Child Lives with:_____ Work Phone:_____ Home Phone:_____

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? Comment?		

CHILD/ADOLESCENT HISTORY

Response Codes: Y=Yes N=No NA=Not applicable

1. Birth Weight_____, Were there any prenatal or delivery problems with this 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:		

Headache_____	Convulsions_____	Diabetes_____	Earaches_____	Back/Spine_____
Colds/Sore Throat_____	Rheumatic Fever_____	Genitalia_____	Oral/Dental_____	Extremity Problems____
Heart/Lung disease_____	Allergies/Asthma_____	Digestive_____	Urinary/Bowel_____	Other_____

List any present concerns of child/parent/guardian:

Name:_____

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform Health Assessments.

Height_____ Weight_____ Hgb or Het_____
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 – Results_____
2. Development: Type of Screen_____Results_____
3. Speech: Type of Screen_____Results_____
4. Hearing: Type of Screen_____Results_____
5. Vision: Type of Screen_____Results_____

Significant Assessment Finding:	Anticipatory Guidance: (Circle those discussed)	
	1. Safety/poisons	8. Lifestyles
	2. Nutrition	9. Development
	3. Parenting	10. Behavior
Recommendations: (to parents, teachers-include any referrals)	4. Family Planning	11. Sexuality
	5. Discipline	12. Dental
	6. Immunizations	13. Other
Follow up:	7. Hygiene	
	Comments:	

RECOMMENDATIONS FOR PHYSICAL EDUCATION:

Full Program_____ Restricted (explain)_____

No Participation (explain)_____

_____

Additional Information may be attached

_____ _____
Signature of Licensed Physician or Nurse approved to perform health assessments Date

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