

### Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

<b>Length/Height:</b> _____ <b>IN/CM</b>	<b>%ILE</b> _____	<b>Weight:</b> _____ <b>LB/KG</b>	<b>%ILE</b> _____
<b>Physical Examination</b>	<input checked="" type="checkbox"/> <b>If Normal</b>	<b>If Abnormal - Comments</b>	
Head/Ears/Eyes/Nose/Throat			
Teeth			
Cardio/Respiratory			
Abdomen/GI			
Genitalia/Breasts			
Extremities/Joints/Back/Chest			
Skin/Lymph Nodes			
Neurologic & Developmental			
<b>Screening Tests</b>	<b>Screening Date</b>	<b>Note Here if Results are Pending or Abnormal</b>	
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Hearing			
Vision			

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)  
 None

Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address	City
Zip Code	