CHILD HEALTH ASSESSMENT

To be filled out by parent or guardian

Name:_____Birthdate_____

Address:_____Birthplace_____

Parent/Guardian_____Phone Number_____

Physician_____Dentist_____

HEALTH HISTORY: **YES** **NO**

1. Was your child premature? If so, how many weeks? (If child was born 3 or more weeks premature. _____Weeks ___ ___
2. Are there any chronic illnesses in your family such as heart disease, diabetes, cancer, seizure disorders, or others? ___ ___
   If yes, explain_____
3. Does any member of the family have a visual defect, hearing loss, or spinal deformity? If yes, explain_____ ___ ___
4. Were there any pre-natal or delivery problems with the child? ___ ___
   If yes, explain_____
5. Did this child walk, talk, and speak at the usual time? ___ ___
6. Does this child have a history of any hospitalization? ___ ___
   If yes, for what?_____
7. Does this child have a problem with being shy or overactive? ___ ___
   If yes, explain_____
8. Does this child have emotional problems? ___ ___
   If yes, explain_____
9. Does this child have any chronic illnesses such as: ___ ___

___Frequent Headaches	___Fainting	___Ear Infections	___Hypoglycemia
___Colds/Sore Throat	___Seizure Disorders	___Dental	___Diabetes
___Heart/Lung Disease	___Rheumatic Fever	___Urinary/Bowel	___Kidney Disease
___Back/Spine	___Allergies	___Head Injuries	___Blood Disorder
___Asthma	___Eczema	___Mental Illness	___Joint/Arthritis

___Other/Explain_____

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_____

CONTINUED…

CHILD HEALTH ASSESSMENT

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

Name:_____DOB:_____Height:_____Weight: _____

Blood Pressure_____Pulse_____Temp_____RR_____

Hgb/HCT_____Urinalysis_____Sickle Cell_____

Other_____

Review of Systems:

Head_____	Lungs_____	CNS_____
EENT_____	Breast_____	Skin_____
Dental_____	Abdomen_____	Lymphatic_____
Cardiovascular_____	Muskuloskeletal_____	GU_____

Screening Results:

Development (type of test)_____

Hearing

Right_____Left_____Type of test_____

Vision

Right_____Left_____Type of test_____

Speech_____

Significant Assessment Findings:_____

_____

_____

Recommendations: (include any special school needs)_____

_____

Do you see this child for regular health supervision? Yes___ No___

Date:_____Signed:_____

CONTINUED….