

**HEALTH ASSESSMENT FORM
FOR COMPLIANCE WITH K.S.A. 72-5214
(Health Assessment at School Entry)**

I hereby consent for my child, _____
to receive a health assessment screening. I understand that this screening includes:
hearing, vision, dental, lead, urinalysis, hemoglobin/hematocrit, nutrition, developmental,
health history, and a complete physical examination.

**If the HEALTH ASSESSMENT FOR CHILDREN AND YOUTH form is used for
school entry, a copy should accompany the student to school.**

Parent/Guardian

Date

Do not write below this line

I certify that _____ has completed the
Child's Name
health assessment required by Kansas Law.

Health Care Provider

Date

Complete and attach this section only if parent refuses to sign consent on Health Assessment for Children and Youth.

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Statement of Consent:

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 or Guardian

Date

Name _____
Address _____
Parent/Guardian _____
Child lives with _____
Number in Household _____
Physician _____
Dentist _____
Eye Doctor _____
School _____

Birth Date _____ Male/Female _____
City _____ State _____
Zip Code _____
Mom Phone/Work _____ Home _____
Dad Phone/Work _____ Home _____
Type of Family Housing _____
Date of last examination _____
Date of last examination _____
Date of last examination _____
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?	_____	_____

CHILD/ADOLESCENT HISTORY

RESPONSE CODES: Y=Yes N=No NA=Not Applicable

	CODE	COMMENT
1. Birth Weight _____. Were there any pre-natal or delivery problems with the 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 medications, 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 (check those that apply):		
Headache _____ Convulsions _____ Diabetes _____ Ear Aches _____ Cold/Sore Throat _____		
Back/Spine/Extremity problems _____ Rheumatic Fever _____ Genitalia _____ Oral/Dental _____		
Heart/Lung Disease _____ Allergies/Asthma _____ Digestive _____ Urinary/Bowel _____		
Other _____		

List present concerns of child/parent/guardian:

PHYSICAL EXAMINATION:

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

Height: _____ Weight: _____ Hgb or Hct: _____
 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

- Nutritional evaluation (all ages-each screen) (check if applicable).
 Enrolled in WIC Receiving vitamin supplement with iron Without Iron Fluoride Supplement
Food intake review. Results:
 Milk/milk products (breast fed/type of formula) _____
 Fruit/vegetables _____
 Meat, beans, eggs _____
 Breads, cereals _____
- Development: Type of screen _____ Results: _____
- Speech: Type of screen _____ Results: _____
- Hearing: Type of screen _____ Results: _____ Date Last Screen: _____
- Vision: Type of screen _____ Results: _____ Date Last Screen: _____

Significant assessment findings:

Anticipatory Guidance (circle those discussed)

- | | |
|--------------------|----------------|
| 1. Safety/poisons | 8. Lifestyle |
| 2. Nutrition | 9. Development |
| 3. Parenting | 10. Behavior |
| 4. Family planning | 11. Sexuality |
| 5. Discipline | 12. Dental |
| 6. Immunizations | 13. Other |
| 7. Hygiene | |

Recommendations (include referrals):

Follow Up:

Comments:

Signature of physician or nurse approved to perform health assessments

Date

Additional information may be attached.