# BLUE VALLEY SCHOOL DISTRICT #229

## HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

*Confidential* Child Health Record (To be released only on signature of parent/guardian)

*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.*

Signature of Parent/Guardian _____ Date _____

| | | | | | |
|---|---|---|---|---|---|
| Name: | | Birthdate: | | Male/Female: | |
| Address: | | City: | | Zip: | |
| Parent/Guardian: | | Phone: Work: | | Home: | |
| Child lives with: | | Phone: Work: | | Home: | |
| 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 | Comments |
|---|---|---|
| 1. Are there any chronic illnesses/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 | Comments |
|---|---|---|
| 1. Birth Weight: _____ Were there any prenatal 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 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 onset 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 daycare? | | |
| k. have any sexuality concerns? | | |
| l. have any chronic illness or disturbing problems with: | | |

❒Headaches ❒Convulsions ❒Diabetes ❒Earaches ❒Back/Spine Extremity Problems
❒Colds/Sore Throat ❒Rheumatic Fever ❒Genitalia ❒Oral/Dental ❒Other
❒Heart/Lung Disease ❒Allergies/Asthma ❒Digestive ❒Urinary/Bowel

List present concerns of child/parent/guardian:

**IMMUNIZATION RECORD**

**PLEASE NOTE: Complete record of immunizations with dates (mm/dd/yy) must accompany this form, signed by the Health Care Provider**

***PLEASE COMPLETE OTHER SIDE***

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**Confidential *Child Health Record (To be released only on signature of parent/guardian)***

Student Name: _____ Birthdate: _____

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

| | | | | | |
|---|---|---|---|---|---|
| Height | | Weight | | Age of onset of menses? | |
| Pulse | | Blood Pressure | | Lead | |
| Urinalysis | | Sickle Cell | | Other | |
| Tuberculosis | | Head Circumference | | | |

Response Codes 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 (all ages – each screen) (✓ all that apply)

Nutrition/WIC questionnaire available from (913) 296-0092

☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with Iron
☐ Fluoride Supplement ☐ Receiving Vitamin Supplement without Iron

Food Intake Review Results:
- milk/milk products (breastfed / type of formula) _____
- fruit / vegetables _____
- meat, beans, eggs _____
- breads, cereals _____

2. Development: Type of screen _____ Results _____
3. Speech: Type of screen _____ Results _____
4. Hearing: Type of screen _____ Results _____
   Date of last screen _____
5. Vision Type of screen _____ Results _____
   Date of last screen _____

Significant Assessment Findings:

_____
_____
_____
_____
_____

Recommendations:

_____
_____
_____
_____

Anticipatory Guidance: (circle those discussed)

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

Physician's Signature: _____ Date: _____

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