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:					
Physician:		Date of last examination:			
Dentist:		Date of last examination:			
Eye Doctor:		Date of last examination:			

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. have a history of vision, speech, hearing or communication problems?		
g. have a problem with being tired or overactive?		
h. have any emotional or behavioral problems?		
i. need any special help in school or daycare?		
j. have any of the following chronic illnesses:		

❒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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Student Name: _____ Birthdate: _____

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

Past Health History (Development-Illness-Hospitalization)

Allergies _____

Current Medications _____

Nutritional Status _____

General Appearance _____ Head – Neck _____

Integument _____ EENT _____

Oral/Dental _____ Thorax _____

Breasts _____ Cardiovascular _____

Abdomen _____ Musculoskeletal _____

Genitourinary _____ Neurological _____

SCREENING TEST (Dates Done, Types of Test, and Results

Development _____ Speech _____

Hearing _____ Vision _____

Urinalysis _____ Tuberculosis _____

Lead _____ Sickle Cell _____

Significant Assessment Findings/Diagnosis:

Recommendations:

Do you see this child for regular health supervision: Yes _____ No _____

Physician/Nurse's Printed Name: _____

Physician/Nurse's Signature: _____ Date: _____

Address of Physician or Nurse: _____