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: ______________________________