HEALTH ASSESSMENT FOR CHILDREN & YOUTH USD #435, Abilene

| Name | | | | | _Male / Female | |
|---|---|---------------------------------|-------------|------------------|---------------------|--|
| Address | ess City | | | Zip | | |
| Parent / Guardian — Physician | | Pho | one | | | |
| ——— | | | | | | |
| FAMILY HEALTH H | | | | | | |
| Response Codes: M = Maternal P = Paternal S = Sibling I | | | | | NA = Not applicable | |
| | | | | Code I | Comment | |
| Are there any chron cancer, convu | ic illness problems i Ilsions, mental illnes | | | | | |
| Does any family me deformity? C | | defect, hearing los | s or spinal | | | |
| 3. Does this child a. See a hea | Ithcare provider regu | ılarly? | | | | |
| b. Use any m | nedication, drugs, or | alcohol? | | | | |
| | tory of any hospitaliz dents? | zations, surgeries | or major | | | |
| d. Have a his | story of any childhoo | d illnesses/disease | es? | | | |
| e. Have a his | story of other commu | nicable diseases? | | | | |
| | tory of hearing, vision lems? | n, speech or comn | nunication | | | |
| g. Have a problem with being tired or overactive? | | | | | | |
| h. Have any emotional or behavioral problems? | | | | | | |
| i. Need any s | pecial help in schoo | l or daycare? | | <u> </u> | | |
| j. Have any c | thronic illness or disa | abling problems wi | th: | | | |
| Headaches | Seizures | Diabetes | Colds/S | Sore throat _ | | |
| Rheumatic fever | Earaches | Oral/Dental Heart/lung problems | | | | |
| Asthma | Digestive | Urinary/bowel | Back/S | Spine/Extemity _ | <u> </u> | |
| Medications currer | ntly taking? Pleas | se list | | | | |
| Allergies to medica | itions? Please lis | st | | | | |
| Allergies to foods? | Please list | | | | | |

Please attach a copy of current immunization record.

| PHYSICAL EXAMINATION: To be co | ompleted by a health c health assessments | eare provider approved to perform S. |
|--|--|---|
| Height | Weight | Hgb |
| Pulse | B/P | |
| UA | | |
| | | |
| Code each item as follows: | Code | Description of findings |
| 0 = No significant findings | | |
| 1 = Significant findings | | |
| General Appearance | | |
| Integument | | |
| Head / Neck | | |
| EENT | | |
| Oral - Dental | | |
| Thorax | | |
| Breasts | | |
| Cardiovascular | | |
| Abdomen | | |
| Musculoskeletal | | |
| Genitourinary | | |
| Neurological | | |
| SCREENING | | |
| 1. Nutritional Status | | |
| 2. Development | | |
| 3. Speech | | |
| 4. Hearing | | |
| 5. Vision | | |
| Significant Assessment Findings: | | |
| Recommendations: | | |
| Follow Up: | | |
| | | |
| Signature of Licensed Physician or Nur | rse approved to perform | Health Assessments Date |

BMG 1/04