USD 440 Halstead-Bentley

Child Health Assessment

Name: _____
Birthdate: _____
Address: _____
Parent/Guardian: _____
Address: _____
Phone: Work_____Home _____ Cell _____

Birthplace: _____
Birth Certificate Number: _____
Physician: _____
Date of last examination: _____
Dentist: _____
Date of last examination: _____

HEALTH HISTORY: To be filled out by parent or guardian

	Yes	No
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions or others?	_____	_____
2. Does any member of your family have a visual defect, hearing loss, or spine deformity?	_____	_____
3. Were there any pre-natal or delivery problems with the child?	_____	_____
4. Did this child walk, talk, and speak at the usual time?	_____	_____
5. Does this child:		
(a) See a physician regularly for any illness problem?	_____	_____
(b) Take any medication regularly?	_____	_____
(c) Have a history of any hospitalization?	_____	_____
(d) Have a history of any childhood diseases?	_____	_____
(e) Have a history of menstrual problems? (if applicable)	_____	_____
(f) Have a problem with vision, speech or hearing?	_____	_____
(g) Have a problem with being shy or overactive?	_____	_____
(h) Have any emotional problems?	_____	_____
(i) Have any chronic illness or handicapping problems such as:	_____	_____

	Yes	No		Yes	No		Yes	No
Headaches	____	____	Convulsions	____	____	Earaches	____	____
Colds/sore throat	____	____	Rheumatic fever	____	____	Dental	____	____
Heart/Lung disease	____	____	Allergies/ Asthma	____	____	Urinary/Bowel	____	____
Back/Spine	____	____	Diabetes	____	____	Other	____	____

PHYSICAL EXAMINATION: To be filled out by physician or nurse approved to do health assessments

Height _____
Weight _____
Head _____
EENT_____
Dental_____

Cardiovascular _____
Lungs _____
Breast _____
Abdomen _____
G.U. _____

CNS _____
Skin _____
Lymphatic _____
Musculoskeletal _____

SCREENING RESULTS

Development (type of test) _____
Hearing: Right_____Left_____
Vision: Right_____Left_____
Speech_____
(Indicate if you wish these tests to be performed at school.)

Pulse_____
Blood Pressure_____
Hgb/HCT _____
Sickle Cell_____
Other _____

SIGNIFICANT ASSESSMENT FINDINGS:

RECOMMENDATIONS: (include any special school needs)

Do you see this child for regular health supervision? Yes ___ No ___

Date _____ Signed _____ Licensed Physician or Nurse

Printed Name_____ Licensed Physician or Nurse