Health Assessment

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 my child's school.

_____
Parent/Guardian Date

Name _____ DOB _____ Male/Female _____

Health history and medical information:

Asthma ____ Allergies ____ Diabetes ____ Seizures ____ Headaches ____ Heart/Lung Disease ____

Digestive ____ Earaches ____ Back/Spine/Extremity problems ____ Oral/Dental ____ Urinary/Bowel ____

Vision concerns ____ Hearing Aids/Hearing loss ____ Speech/Communication problems ____

Hospitalizations/Surgeries ____ History of Childhood Disease/Illnesses ____

Please comment on above: _____

_____

_____

Allergies to Food/Medication _____

Current Medications _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance		
Integument/Lymph Nodes		
Head/Neck		
Eyes/Ears/Nose/Throat		
Oral - Dental		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Musculoskeletal/Joints/Back		
Neurologic/Developmental		
Nutritional Status		

Hearing _____ Vision _____

Recommendations/Referrals _____

_____ _____
Signature of Physician/PA/APRN/RN approved to perform health assessments Date