Confidential Child Health Record (To be released on signature of parent/guardian.)

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

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.

_____ _____
Parent or Guardian Date

Name _____ Birth Date _____ Male/Female _____
Address _____ City _____ State _____
_____ Zip Code _____
Parent/Guardian _____ Mom Phone/Work _____ Home _____
Child lives with _____ Dad Phone/Work _____ Home _____
Number in Household _____ Type of Family Housing _____
Physician _____ Date of last examination _____
Dentist _____ Date of last examination _____
Eye Doctor _____ Date of last examination _____
School _____ Community Services _____

FAMILY HEALTH HISTORY

RESPONSE CODES: M=Maternal P=Paternal S=Sibling NA=Not Applicable

	CODE	COMMENT
1. Are there any chronic illness 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	COMMENT
1. Birth Weight _____. Were there any pre-natal 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 medications, 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. Age of menarche _____. Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		

l. Have any chronic illness or disabling problems with (check those that apply):

Headache _____ Convulsions _____ Diabetes _____ Ear Aches _____ Cold/Sore Throat _____
Back/Spine/Extremity problems _____ Rheumatic Fever _____ Genitalia _____ Oral/Dental _____
Heart/Lung Disease _____ Allergies/Asthma _____ Digestive _____ Urinary/Bowel _____
Other _____

List present concerns of child/parent/guardian:

COPY OF ORIGINAL IMMUNIZATION RECORD NEEDS TO BE ATTACHED