## HEALTH ASSESSMENT FORM FOR COMPLIANCE WITH K.S.A. 72-5214 (Health Assessment at School Entry)

I hereby consent for my child,											
to receive a health assessment screening. I understand that this screening includes: hearing, vision, dental, lead, urinalysis, hemoglobin/hematocrit, nutrition, developmental, health history, and a complete physical examination.											
										If the HEALTH ASSESSMENT FO	OR CHILDREN AND YOUTH form is d accompany the student to school.
	Parent/guardian										
	Date										
Do not write below this line											
I certify that	has competed the health assessment screening										
Child's name required by Kansas law.											
	Health Care Provider										
	Date										

Complete and attach this section only if parent refuses to sign consent on Health Assessment form for Children and Youth.

## HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Statement of Consent:											
In order to better serve th				d, I hereb	y give m	y permiss	ion for the tra	ansfer of l	nealth s	screening r	ecords to school
and other appropriate hea	alth prot	essionais	S.								
					Parent	Parent or guardian					Date
Name:					Birth date: Male/Female						
Address:											
					Zip: _						
	Parent/Guardian:					Phone/Work: Home:					
	s with:				Phone/Work: Home:						
Number in household:											
Physician:					Date of last examination:						
Dentist:					Date	of last ex	amination:				
Eye Doctor:											
School:					Comi	nunity S	ervices:				
FAMILY HEALTH HIST Response Codes: M		nol	D _ 1	Datamal		C _Ciblin	NIA _	Not annli	aabla		
Response Codes: M	= Mater	nai	P = .	Paternai	2	S =Sibling	, INA =	Not applie	cable.		Tomamont.
1 Arathara any ahrania	illness n	robloma	in vour f	Family and	ah as haa	rt diagona	diabatas	Code		(	Comment
1. Are there any chronic cancer, convulsions, n	-		•	•							
2. Does any family mem									<b></b>		
Comment?	oci nave	a vision	derect, ii	caring ios	ss, or spin	iai acioiii	iity .				
CHILD/ADOLESCENT 1	HISTOR	Y					_		<b>1</b>		
Response Codes: Y		<u> </u>	N = No		NA = Nc	ot applica	ble.				
•								Code	_	(	Comment
1. Birth weight					ery prob	lems with	the child? _		<b>_</b>		
2. Did this child walk, tal		evelop at	the usua	al time?			_		ļ		
<ol><li>Does this child/adoles</li></ol>											
a. See a health care pr		-					_		<b>!</b>		
b. Use any medication									<b>!</b>		
c. Have a history of an					ergency	room vis	ts?		<b></b>		
d. Have a history of a							_		<del> </del>		
e. Have a history of or					atmaal mu	ahlama?	_		<del> </del>		
f. Age of menarche g. Have a history of v							_				
					cation pro	obiems?	_		<del> </del>		
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 con		.001 01 01	ay cure.				_				
1. Have any chronic ill		disabling	problem	ns with (cl	heck thos	se that ap	oly):				
Headache		_	_	_ Diabe			r aches _	В	ack/spi	ine/extremi	ty problems
Cold/sore throat				_ Genita			al/dental _		1		J 1
Heart/lung disease				Diges			rinary/bowel_	0	ther: _		
<i>C</i>		Ü					•				
ist present concerns of cl	hild/pare	ent/guard	lian:								
ist present concerns of ci	.iiid/paic	,iii/ guai u	nan.								
mmunization: Record dat	te of eacl	h dose re	ceived (1	mm/dd/yy	y)						
	1 st	2nd	3rd	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>		18	t	<b>2</b> nd	3 <sup>rd</sup>
DDE		/-		† *		0	7 53 5-	•		/.	, ,
DPT		<u> </u>	1	1			MMF	ζ			
Td/DT							HBV	J			
											•
OPV or IPV		<u> </u>									

**	Blo	ood Pressure:	Hgb or H Lead Other	Hct:
Code each item as follow	ws: Code		Description of Findin	gs
0 = No significant finding 1 = significant findings			Description of I main	50
General appearance				
Integument				
Head - neck				
EENT				
Oral - dental				
Thorax				
Breasts				
Cardiovascular				
Abdomen				
Musculoskeletal				
Genitourinary				
Neurological				
" Enrolled in WIC Food intake review. R	Receiving vi	tamin supplement with iro	n " Without iron	vailable from 785-296-0092.  "Fluoride supplement  Date last screen:
<ul><li>4. Hearing:</li><li>5. Vision:</li></ul>				Date last screen:
Significant assessment for Recommendations (include	-		<ol> <li>Safety/poisons</li> <li>Nutrition</li> <li>Parenting</li> </ol>	(circle those discussed) 8. Lifestyle 9. Development 10. Behavior
Follow Up:			<ul><li>4. Family planning</li><li>5. Discipline</li><li>6. Immunizations</li><li>7. Hygiene</li><li>Comments:</li></ul>	<ul><li>11. Sexuality</li><li>12. Dental</li><li>13. Other</li></ul>
Additional information m	ay be attached			
	Date	Signature of physici	an or nurse approved to perf	orm health assessments

**PHYSICAL EXAMINATION**: To be completed by health care provider approved to perform health assessments.