

HEALTH ASSESSMENT FORM FOR COMPLIANCE

CHILD'S NAME _____ **SEX** _____

DATE OF BIRTH _____

MOTHER'S NAME (OR GUARDIAN) _____

ADDRESS - HOME _____

TELEPHONE - HOME _____

ADDRESS - BUSINESS _____

TELEPHONE - BUSINESS _____

FATHER'S NAME (OR GUARDIAN) _____

ADDRESS - HOME _____

TELEPHONE - HOME _____

ADDRESS - BUSINESS _____

TELEPHONE - BUSINESS _____

FAMILY PHYSICIAN _____

TELEPHONE NUMBER _____

I hereby consent for my child, _____, to
receive a health assessment screening.

If the **HEALTH ASSESSMENT FOR CHILDREN AND YOUTH** form
is used for school entry, a copy should accompany the student to school.

Parent/Guardian

Date

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/Guardian

Date

Have any chronic illness or disabling problems with:

Headache	_____	Convulsions	_____	Rheumatic Fever	_____
Diabetes	_____	Colds/Sore Throat	_____	Allergies/Asthma	_____
Genitalia	_____	Heart/Lung Disease	_____	Urinary/Bowel	_____
Earaches	_____	Back/Spine/Extremity	_____	Oral/Dental	_____
Digestive	_____	Problems	_____	Other	_____

HEARING, VISION, SPEECH PROBLEMS:

PAST HEALTH HISTORY (DEVELOPMENTAL – ILLNESS – HOSPITALIZATION):

ALLERGIES _____

CURRENT MEDICATIONS _____

PHYSICAL EXAMINATION:

HEIGHT _____ WEIGHT _____

HEAD _____	ABDOMEN _____
EENT _____	GU _____
TEETH _____	GYN _____
HEART _____	SKELETAL _____
LUNGS _____	NEUROLOGICAL _____

SCREENING TEST (DATES DONE AND RESULTS):

VISION _____	TBC. TEST _____
HEARING _____	OTHER _____
SPEECH _____	HGB. _____
DDST _____	U.A. _____

RECOMMENDATIONS:

Physician Signature

Date