

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Name _____ Birthdate _____ Male/Female _____

Address _____ City _____ Zip _____

Parent/Guardian _____ Phone: - Work _____ Home _____

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

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

Significant Assessment Findings:

Recommendations: (Include referrals)

Follow Up:

Additional Information may be attached

Date

Signature of Licensed Physician or Nurse approved to perform health assessments

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