

CHILD HEALTH ASSESSMENT

The Child Health Assessment is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form, is required for all children including children of the provider or staff in licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Child Health Assessment is optional for children in Registered Family Day Care Homes. A Kan-Be-Healthy Assessment Form is a KDHE form and is acceptable. A School Health Assessment Form is also acceptable for school-age children or youth.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____

PHYSICAL EXAMINATION:

HEIGHT _____

WEIGHT _____

HEAD _____

ABDOMEN _____

EENT _____

GU _____

TEETH _____

GYN _____

HEART _____

SKELETAL _____

LUNGS _____

NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS)

VISION _____

TBC. TEST _____

HEARING _____

SICKLE CELL _____

SPEECH _____

HGB. _____

DDST _____

U.A. _____

OTHER _____

DIAGNOSIS:

RECOMMENDATION:

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION: YES _____ NO _____

Signature of Licensed Physician or Nurse Approved for Child Health Assessments

Date (MM/DD/YYYY)

Print the Name of the Individual Signing Above

Phone #

Address of Physician or Nurse

City

Zip Code

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED FOR EACH CHILD IN REGISTERED FAMILY DAY CARE HOMES, LICENSED DAY CARE AND GROUP DAY CARE HOMES, CHILD CARE CENTERS AND PRESCHOOLS.

PARENTS MAY TRANSFER THIS FORM WHEN THEIR CHILD MOVES TO ANOTHER REGULATED CHILD CARE FACILITY IN KANSAS.

MEDICAL STAFF ASSESSMENT (FILLED OUT BY LICENSED HEALTH CARE PROFESSIONAL)

AGE:	YRS	MOS	HEIGHT:	cm(%ile)	WEIGHT:	kgs.(%ile)	BP	/	P
			HEIGHT:	in	WEIGHT:	lbs.			
VISUAL ACUITY:		RIGHT	LEFT	tested with/without lenses			NORMAL	ABNORMAL	
			NORMAL	ABNORMAL	N/A		COMMENTS		
1. EYES									
2. EARS, NOSE & THROAT									
3. HEARING									
4. MOUTH AND TEETH									
5. NECK (SOFT TISSUE)									
6. CARDIOVASCULAR									
7. CHEST AND LUNGS									
8. ABDOMEN									
9. GENITALIA - HERNIA									
10. SKIN AND LYMPHATICS									
11. NECK									
12. SPINE - SCOLIOSIS									
13. EXTREMITIES									
14. NEUROLOGICAL									
15. WEARS GLASSES/CONTACTS									
16. WEARS DENTAL BRIDGES									
17. WEARS BRACES/PLATES									

BASED ON THIS HX AND PX EXAM, THE FOLLOWING ABNORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ON-GOING MEDICATION

TYPE	DOSAGE	FREQUENCY	ALLERGIES	
			TYPE	REACTION

PARTICIPATION RECOMMENDATIONS

- | | |
|--|---|
| <input type="checkbox"/> NORMAL PHYSICAL ACTIVITIES INCLUDING PE | <input type="checkbox"/> CONTACT SPORTS |
| <input type="checkbox"/> CHILD AND YOUTH SERVICES | <input type="checkbox"/> NON-CONTACT SPORTS |
| <input type="checkbox"/> COLLISION SPORTS | <input type="checkbox"/> HIGH RISK |

THIS STUDENT HAS A HEALTH PROBLEM WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

- NO
 YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

SPORTS PHYSICAL IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE _____ LICENSED HEALTH CARE PROFESSIONAL STAMP _____

LICENSED HEALTH CARE PROFESSIONAL SIGNATURE _____