HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Name_____ Birthdate_____ Male/Female_____

Address_____ City_____ Zip_____

Parent/Guardian_____ Phone (W)_____(H)_____

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