School Health Assessment Record
Manhattan Catholic Schools
Manhattan, Kansas
School Year ____/____

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

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 Manhattan Catholic Schools.

_____ _____
Parent/Guardian Date

Dear Parent/Guardian:
A health assessment is very important for every student's general welfare, and for the school to have an understanding of individual needs. A physical examination is required upon initial entrance into Kansas Schools for all students age 8 and under and recommended for all others.

NAME_____
SCHOOL_____
ADDRESS_____ GRADE_____ SEX_____
BIRTHDATE____/____/____ CHILD LIVES WITH:_____
PHYSICIAN_____ DENTIST_____

CHILD HEALTH HISTORY: (Completed by Parent/Guardian)

1. Birthweight_____. Were there any pre-natal or delivery problems with the child? If so, please explain:

2. Did this child walk, talk, and develop at the usual time? Please explain:

3. Does this child/adolescent:
   a. Use any medication? If so, please list:

   b. Have history of any hospitalizations? If so, please explain (cause, duration of stay, frequency, etc.)

   c. Have a history of any childhood diseases/illnesses? If so, please list:

   d. Have any emotional or behavioral problems? If so, please describe:

   e. Have any chronic illness or disabling problems with (check all that apply):
      Headaches____Convulsions____Digestive____Fainting____Earaches____
      Heart/Lung disease____Allergies/Asthma____Oral/Dental____Back/Spine____
      Diabetes____Urinary/Bowel____Extremity problems____Nose Bleeds____
      Cancer____Other____

List present concerns of child/parent/guardian and explain any of above items checked:

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER APPROVED TO PERFORM HEALTH ASSESSMENTS ACCORDING TO KANSAS LAW.

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____
PULSE_____ HBG/HCT_____ LEAD_____ UA_____
SICKLE CELL_____ OTHER_____
TUBERCULOSIS DATE GIVEN_____ DATE READ_____
NEG____POS____MM_____

Code Each Item as Follows: Code Description of Findings

0=No Significant Findings
1=Significant Findings

General Appearance

Integument

Head/Neck

EENT

Oral/Dental

Thorax

Cardiovascular

Abdomen

Musculoskeletal

Genitourinary

Neurological

SCREENING

1. HEARING: TYPE OF SCREEN_____RESULTS: R:_____L:_____
2. VISION: TYPE OF SCREEN_____RESULTS: R:_____L:_____
WITH GLASSES - YES_____NO_____

SIGNIFICANT ASSESSMENT FINDINGS:

RECOMMENDATIONS: (INCLUDE REFERRALS)

FOLLOW UP:

MCS 9/98

_____ Date

_____
Signature of Licensed Physician or Nurse approved to perform health assessments