

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 _____
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