

HEALTH ASSESSMENT FORM FOR COMPLIANCE  
WITH K.S.A. 72-5214 (Health Assessment at School Entry)

I hereby consent for my child, \_\_\_\_\_,  
to receive a health assessment screening. I understand that this screening includes:  
hearing, vision, dental, lead, urinalysis, hemoglobin/hematocrit, nutrition,  
developmental, health history, and a complete physical examination.

**If the HEALTH ASSESSMENT FOR CHILDREN AND YOUTH form is  
used for school entry, a copy should accompany the student to school.**

\_\_\_\_\_  
Parent/guardian

\_\_\_\_\_  
Date

Do not write below this line  
-----

I certify that \_\_\_\_\_ has completed the health assessment screening  
Child's name  
required by Kansas law.

\_\_\_\_\_  
Health Care Provider

\_\_\_\_\_  
Date

Complete and attach this section only if parent refuses to sign consent on Health Assessment form for Children and Youth.



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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hgb or Hct: \_\_\_\_\_  
 Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Lead \_\_\_\_\_  
 Urinalysis: \_\_\_\_\_ Sickle Cell: \_\_\_\_\_ Other \_\_\_\_\_  
 Tuberculosis: \_\_\_\_\_ Head Circumference: \_\_\_\_\_

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		

**SCREENING**

1. Nutritional evaluation (all ages - each screen ) ( / if applicable). Nutrition/WIC questionnaires available from 785-296-0092.  
 " Enrolled in WIC " Receiving vitamin supplement with iron " Without iron " Fluoride supplement

**Food intake review. Results:**

milk/milk products (breast fed/type of formula) \_\_\_\_\_  
 fruit/vegetables \_\_\_\_\_  
 Meat, beans, eggs \_\_\_\_\_  
 breads, cereals \_\_\_\_\_

2. Development: Type of screen \_\_\_\_\_ Results: \_\_\_\_\_  
 3. Speech: Type of screen \_\_\_\_\_ Results: \_\_\_\_\_  
 4. Hearing: Type of screen \_\_\_\_\_ Results: \_\_\_\_\_ Date last screen: \_\_\_\_\_  
 5. Vision: Type of screen \_\_\_\_\_ Results: \_\_\_\_\_ Date last screen: \_\_\_\_\_

Significant assessment findings:

Recommendations (include referrals):

Follow Up:

Anticipatory Guidance (circle those discussed)

- |                    |                |
|--------------------|----------------|
| 1. Safety/poisons  | 8. Lifestyle   |
| 2. Nutrition       | 9. Development |
| 3. Parenting       | 10. Behavior   |
| 4. Family planning | 11. Sexuality  |
| 5. Discipline      | 12. Dental     |
| 6. Immunizations   | 13. Other      |
| 7. Hygiene         |                |

Comments:

Additional information may be attached

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of physician or nurse approved to perform health assessments

