Confidential Child Health Record (To be released only on signature of parent/guardian.)

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 school and other appropriate health professionals.

_____ _____
Parent or guardian Date

Name: _____ Birth date: _____ Male/Female: _____
Address: _____ City: _____
_____ Zip: _____
Parent/Guardian: _____ Phone/Work: _____ Home: _____
Child lives with: _____ Phone/Work: _____ Home: _____
Number in household: _____ Type of family housing: _____
Physician: _____ Date of last examination: _____
Dentist: _____ Date of last examination: _____
Eye Doctor: _____ Date of last examination: _____
School: _____ Community Services: _____

FAMILY HEALTH HISTORY

Response Codes: M = Maternal P = Paternal S =Sibling NA = Not applicable.

	Code	Comment
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, or others? Comment?		
2. Does any family member have a vision defect, hearing loss, or spinal deformity? Comment?		

CHILD/ADOLESCENT HISTORY

Response Codes: Y = Yes N = No NA = Not applicable.

	Code	Comment
1. Birth weight _____. Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk, and develop at the usual time?		
3. Does this child/adolescent:		
a. See a health care provider regularly?		
b. Use any medication, drugs, or alcohol?		
c. Have a history of any hospitalizations, surgeries or emergency room visits?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Age of menarche _____. Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		

l. Have any chronic illness or disabling problems with (check those that apply):

Headache _____ Convulsions _____ Diabetes _____ Ear aches _____ Back/spine/extremity problems
Cold/sore throat _____ Rheumatic fever _____ Genitalia _____ Oral/dental _____ _____
Heart/lung disease_____ Allergies/asthma _____ Digestive _____ Urinary/bowel_____ Other: _____

List present concerns of child/parent/guardian:

Immunization: Record **date** of each dose received (mm/dd/yy)

	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DPT							MMR			
Td/DT							HBV			
OPV or IPV										
HIB										

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:

Additional information may be attached

Anticipatory Guidance (circle those discussed)

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

Comments:

_____ Date

_____ Signature of physician or nurse approved to perform health assessments

KANSAS STATE HIGH SCHOOL ACTIVITIES ASSOCIATION
PO Box 495, 601 SW Commerce Place; Topeka, KS 66601-0495; (785) 273-5329

PPE

HISTORY
PRE-PARTICIPATION PHYSICAL EVALUATION

Name _____ Sex _____ Age _____ Date of birth _____

TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT AND PARENT OR GUARDIAN

Grade _____ School _____ Sport(s) _____

Address _____ Phone ( ) _____

Personal physician _____ Parent Email _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

PPE shall not be taken earlier than May 1 preceding the school year for which it is applicable.
STUDENT/PARENT/GUARDIAN - answer questions below PRIOR TO EXAMINATION by physician.
Explain "YES" answers in space below. Circle the number of the questions you do not know.

	YES	NO	
1.	☐	☐	Have you had a medical illness or injury since your last check up or sports physical?
	☐	☐	Do you have an ongoing or chronic illness?
2.	☐	☐	Have you ever been hospitalized overnight?
	☐	☐	Have you ever had surgery?
3.	☐	☐	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?
	☐	☐	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?
4.	☐	☐	Do you have any allergies *(for example, to pollen, medicine, food, or stinging insects)*? Have you ever had a rash or hives develop during or after exercise?
5.	☐	☐	Have you ever passed out during or after exercise?
	☐	☐	Have you ever been dizzy during or after exercise?
	☐	☐	Have you ever had chest pain during or after exercise?
	☐	☐	Do you get tired more quickly than your friends do during exercise?
	☐	☐	Have you ever had racing of your heart or skipped heartbeats?
	☐	☐	Have you had high blood pressure or high cholesterol?
	☐	☐	Have you ever been told you have a heart murmur?
	☐	☐	Has any family member or relative died of heart problems or of sudden death before age 50?
	☐	☐	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
	☐	☐	Has a physician ever denied or restricted your participation in sports for any heart problems?
6.	☐	☐	Do you have any current skin problems (for example itching, rashes, acne, warts, fungus, or blisters)?
7.	☐	☐	Have you ever had a head injury or concussion? When? _____ How many? _____
	☐	☐	Have you ever been knocked out, become unconscious, or lost your memory?
	☐	☐	Have you ever had a seizure?
	☐	☐	Have you ever had numbness or tingling in your arms, hands, legs, or feet?
	☐	☐	Have you ever had a stinger, burner, or pinched nerve?
8.	☐	☐	Have you ever become ill from exercising in the heat?
9.	☐	☐	Do you cough, wheeze, or have trouble breathing during or after activity?
	☐	☐	Do you have asthma?
	☐	☐	Do you use an inhaler before excercise?
	☐	☐	Do you have seasonal allergies requiring medical treatment?

	YES	NO	
10.	☐	☐	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position *(for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)*?
11.	☐	☐	Have you had any problems with your eyes or vision?
	☐	☐	Do you wear glasses, contacts, or protective eyewear?
12.	☐	☐	Have you ever had a sprain, strain, fracture or dislocation of a muscle, tendon, bone or joint?

If yes, check appropriate box and explain below.

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper arm		☐ Foot

13.	☐	☐	Do you want to weigh more or less than you do now?
	☐	☐	Do you lose weight regularly to meet weight requirements for your sport?
14.	☐	☐	Has a doctor told you or a family member that you are at risk for blood disorders? Ex: Sickle Cell, etc...
15.	☐	☐	Were you born without or are you missing a kidney, testicle or any other organs?
16	☐	☐	Do you feel that you have fatigue or increased shortness of breath with activity?
17.	☐	☐	Do you have any concerns that you would like to discuss with the doctor?

FEMALES ONLY

18.	☐	☐	Have you begun menstruation?
	☐	☐	If yes, are you ever experiencing any problem (i.e., irregularity, pain, etc.)?

IDENTIFY "YES" ANSWERS *(by number)*

_____

_____

_____

_____

_____

_____

_____

PHYSICAL EXAMINATION

PRE-PARTICIPATION PHYSICAL EVALUATION

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ Blood Pressure. _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal Unequal

Date of recent immunizations: Td _____ Tdap _____ Hep B _____

Varicella _____ HPV _____ Meningococcal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only.

CLEARANCE

☐ Cleared for all activities

☐ Not cleared for: _____

Reason: _____

Recommendations: _____

I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Name of physician *(print/type)* _____ **Date** _____

Address _____ Phone ( ) _____

Signature of physician _____ **, MD, DO, DC or RPA**

(please circle)