(14) New Student Health Assessment for Children and Youth

Student name _____
(Last) *(First)* *(Middle)*

Date of birth _____ Gender (please circle one) M / F

Address _____ City _____ State _____ Zip _____

Parent/guardian _____ Work phone (___) _____ Home phone (___) _____

Physical examination. *To be completed by health care provider approved to perform health assessments.*
Height _____ Weight _____ Pulse _____ Blood pressure _____

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 (including referrals):

Follow-up:

Additional information may be attached as needed.

_____ _____
Date *Signature of licensed physician or nurse approved to perform health assessments*

Statement of parental 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/legal guardian signature _____ Date _____