Manhattan-Ogden USD 383
Manhattan, Kansas

# SCHOOL HEALTH ASSESSMENT
# SCHOOL YEAR 20__- 20__

Statement of Content:
In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to the Manhattan-Ogden USD 383.

_____ _____
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. All students up to the age of nine shall submit evidence they have undergone a health assessment prior to entering kindergarten or before enrolling in the district for the first time. A health assessment is recommended for all others.

NAME_____ PHONE _____

ADDRESS_____ CELL or ALT. PHONE _____

SCHOOL_____ GRADE_____ SEX____ BIRTHDATE____/_____/_____

CHILD LIVES WITH:_____ WORK PHONE _____

PHYSICIAN: _____ DENTIST: _____

CHILD HEALTH HISTORY: (Completed by Parent)

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 a 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:
      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:

   _____

   _____

NAME _____ DATE OF BIRTH _____

**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 _____ URINALYSIS _____

SICKLE CELL_____ OTHER_____

TUBERCULOSIS-DATE GIVEN _____ DATE READ _____ NEG. _____ POS. _____ MM ____

| Code Each Item as Follows:<br>0 = No Significant Findings<br>1 = Significant Findings | Code | Description of 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 ASSESMENT FINDINGS:

RECOMMENDATIONS: (INCLUDE REFERRALS)

FOLLOW UP:

_____ _____

Signature of Licensed Physician or nurse approved to perform health assessments

Address

_____ _____

Title

Date