

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Name _____ Birthdate _____ Male/Female _____

Address _____ City _____ Zip _____

Parent/Guardian _____ Phone (W) _____ (H) _____

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

Code each item as follows: 0 = No significant findings 1 = Significant findings

System	Code	Description of Findings
General Appearance		
Integument		
Head – Neck		
EENT		
Oral – Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

Significant Assessment Findings:

Recommendations: **(Include referrals)**

Additional information may be attached

Date _____
Signature of Licensed Physician, RPA, ARNP or RN certified by KDHE to perform health assessments

Print Name of Licensed Physician, RPA, ARNP or RN certified by KDHE to perform health assessments