

St. Dominic Catholic School
617 JC Street
Garden City, KS 67846
**CHILD HEALTH ASSESSMENT
(PHYSICAL FORM)**

CHILD'S NAME _____ BIRTHDATE _____

Parent/Guardian _____ Address _____

Parents fill out this part: Health History of student

- | | | |
|--|-------|-------|
| 1. Are there any chronic illness problems in your family such as heart Disease, diabetes, cancer, convulsions or others? | YES | NO |
| _____ | _____ | _____ |
| 2. Does any member of family have a visual defect, hearing loss, Or spine deformity? | | |
| _____ | | |
| 3. Were there any pre-natal of delivery problems with this child? | | |
| _____ | | |
| 4. Did this child walk, talk, and speak at the usual time? | | |
| _____ | | |
| 5. Does this child: | | |
| See a physician regularly for any illness problem? | | |
| Take any medication regularly? | | |
| Have a history of any hospitalization? | | |
| Have a problem with vision, speech, or hearing? | | |
| Have a problem with being shy or overactive? | | |
| Have any emotional problems? | | |
| Need any special help in school? | | |
| Have any chronic illness or handicapping problems such as: | | |

| | Yes/No | | Yes/No | | Yes/No |
|--------------------|--------|------------------|--------|---------------|--------|
| Headaches | _____ | Convulsions | _____ | Earaches | _____ |
| Colds/sore Throats | _____ | Rheumatic Fever | _____ | Dental | _____ |
| Heart/Lung Disease | _____ | Allergies/Asthma | _____ | Urinary/Bowel | _____ |
| Back/Spine problem | _____ | Diabetes | _____ | Other | _____ |

REMARKS: (Please explain any problems checked)

Signature of parent/guardian _____ Date _____

******IMPORTANT******

1. **Physical given by physician on backside of this sheet**
2. **Make sure physician signs the back**

**THIS SIDE TO BE COMPETED BY PHYSICIAN OR NURSE
APPROVED TO DO HEALTH ASSESSMENTS.**

HEIGHT _____ WEIGHT _____

HEAD _____ LUNGS _____ CNS _____

EENT _____ BREAST _____ SKIN _____

DENTAL _____ ABDOMEN _____ LYMPHATIC'S _____

CARDIOVASCULAR _____ G.U. _____ MUSCULOSKELETAL _____

Screening Results:

Developmental (type test) _____ Pulse _____

Hearing

Right _____ Left _____

Vision

Right _____ Left _____ Both _____

Speech _____

Pulse _____ Blood Pressure _____ Hbg or HCT _____

Urinalysis _____ Sickle Cell _____ Other _____

Significant Assessment Findings:

Recommendations: (include any special school needs)

Do you see this child for regular health supervision? Yes ____ No ____

Date: _____ Signed _____