

# COASTAL COMMUNITY ACTION, INC

## CHILDREN'S SERVICES HEALTH ASSESSMENT REPORT

PARENT COMPLETE

**Please Print Clearly**

Child's Name \_\_\_\_\_ (Last) (First) (Middle)  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parental Consent : I agree to allow my child's health care provider and CCA Head Start personnel to discuss information on this form.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Health Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Immunizations - Attach a copy of immunization record**

**Pertinent Illnesses, Risks or Developmental Problems: (Check all that apply)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Allergy            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Orthopedic Problems                                  |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Emotional/Behavioral | <input type="checkbox"/> Prematurity (<32 wks. EGA)                           |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Encopresis           | <input type="checkbox"/> Seizures/Convulsions                                 |
| <input type="checkbox"/> Attention/Learning | <input type="checkbox"/> Enuresis (Daytime)   | <input type="checkbox"/> Sickle Cell Anemia                                   |
| <input type="checkbox"/> Bleeding Problems  | <input type="checkbox"/> Genetic Disorders    | <input type="checkbox"/> Speech/Language                                      |
| <input type="checkbox"/> Cancer/Leukemia    | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> at risk for TB |
| <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Hearing Problems     | <input type="checkbox"/> Vision Problems                                      |
| <input type="checkbox"/> Cystic Fibrosis    | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Dental Problems    |   |   |
| <input type="checkbox"/> <b>NONE</b>        |   |   |

**Lead:** date of test/results: \_\_\_\_/\_\_\_\_/\_\_\_\_ date of test/results: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Head Start requires a **blood lead test** at 12 and 24 months of age, please note all past test dates and applicable results

**Screening Results**

| Development | Screening Tool(s) Used:   | Within Normal            | Concern Identified       | Referred to Specialist   | Comments |
|-------------|---|--------------------------|--------------------------|--------------------------|----------|
|             | <input type="checkbox"/> 1 - PEDS<br><input type="checkbox"/> 2 - ASQ<br><input type="checkbox"/> 3 - IDI/CDI<br><input type="checkbox"/> 4 - PSC<br><input type="checkbox"/> 5 - ASQ-SE<br><input type="checkbox"/> 6 - Brigance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |

| Hearing | Screening Tool Used:   | 1000 Hz | 2000 Hz | 4000 Hz | Comments   |
|---------|--|---------|---------|---------|--|
|         | <input type="checkbox"/> OAE<br><input type="checkbox"/> Audiometry<br><input type="checkbox"/> Subjective (ages 0-3 only) | Right   | Left    | Right   | <input type="checkbox"/> Pass<br><input type="checkbox"/> Re-screen scheduled due to middle ear fluid. Re-screen in ____ wks.<br><input type="checkbox"/> Referral to Audiologist/ENT<br><input type="checkbox"/> Previously diagnosed with hearing loss, no screening needed. |

| Vision | Far:       | Both | Right | Left | Comments  |
|--------|------------|------|-------|------|---|
|        | Test Used: |      |       |      | <input type="checkbox"/> Pass<br><input type="checkbox"/> Referral to Eye Doctor (check if Y)<br>Refer if worse than 20/40 in either eye, a two line difference between eyes or <u>unable to test</u> .<br><input type="checkbox"/> Child has a diagnosed vision condition AND has had an eye exam in last 12 months. |

| Physical Examination   | Normal                   | Abnormal                 | Dental Referral made     |
|--|--------------------------|--------------------------|--------------------------|
| Weight: ____lbs. Height: ____ft. ____in.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Body Mass Index (BMI) - for age  | <input type="checkbox"/> | <input type="checkbox"/> | If yes:                  |
| <input type="checkbox"/> 1 - Normal<br><input type="checkbox"/> 2 - Abnormal<br><input type="checkbox"/> 3 - At-Risk (85%ile to <95%ile)<br><input type="checkbox"/> 4 - Overweight (95%ile) | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Blood Pressure: ____/____ or <input type="checkbox"/> n/a  | <input type="checkbox"/> | <input type="checkbox"/> | Dentist                  |
| Hematocrit: ____% OR Hemoglobin: ____gm/dl   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| <input type="checkbox"/> 1 - Within normal range<br><input type="checkbox"/> 2 - >90th percentile (____%ile)   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Vision/Eyes  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| HEENT  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Dental (0-2 yrs. = scrng)  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Lungs  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Cardiac  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Abdomen  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Neurological   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Back/Extremities   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Genital  | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Skin   | <input type="checkbox"/> | <input type="checkbox"/> |                          |

**Health Care Professional's Certification**

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Provider's Signature: \_\_\_\_\_  
 Practice/Clinic Name: \_\_\_\_\_  
 Practice/Clinic Address: \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Stamp Here

HEALTH CARE PROVIDER COMPLETE