Orchard Place
Health Screen

Indicate whether your child has any of the health conditions and diseases listed below. Check the appropriate box. This information will allow the assigned staff member to begin to understand your child while he/she listens to your current concerns.

Client's Full Name _____ **Today's Date** _____

Date of Birth _____ **Gender** ☐ Female ☐ Male ☐ Other **Your Relationship to Client** _____

Has the client had the following examinations in the past year:

Physical Exam? ☐ Yes ☐ No **Date of Last Physical Exam** _____ **Staff Initials** _____*

Dental Exam? ☐ Yes ☐ No **Date of Last Dental Exam** _____ *initials confirm referral was made

Visual Exam? ☐ Yes ☐ No **Date of Last Vision Exam** _____

If the client has **not** had a physical examination within the past year, please make an appointment with your medical provider for one (excludes OP Campus). If you need assistance locating a medical provider, please make the assigned staff member aware of your need.

	N/A	Past Issue	Still Exists	Comment
Allergies (environment)	☐	☐	☐	
Allergies (latex/medication)	☐	☐	☐	
Asthma	☐	☐	☐	
Bladder/Urinary	☐	☐	☐	
Cancer	☐	☐	☐	
Chronic Constipation/ Diarrhea	☐	☐	☐	
Dental Problems	☐	☐	☐	
Diabetes	☐	☐	☐	
Ear/Vision Problems	☐	☐	☐	
Eczema/Skin Issues	☐	☐	☐	
Epilepsy	☐	☐	☐	
Fainting	☐	☐	☐	
Head Injury	☐	☐	☐	
Hearing Loss	☐	☐	☐	
Heart Problems	☐	☐	☐	
Migraines/ Chronic Headaches	☐	☐	☐	
Neurological Disorder	☐	☐	☐	
Reproductive Issues	☐	☐	☐	
Respiratory Infections		☐	☐	
Seizures	☐	☐	☐	
Sleep Problems	☐	☐	☐	
Sore Throats/Tonsillitis	☐	☐	☐	
Stomach Aches	☐	☐	☐	
Unexplained Fever	☐	☐	☐	
Other	☐	☐	☐	

For any current health conditions and/or diseases, is the client receiving medical treatment or follow up? ☐ **Yes** ☐ **No**

If "No", please explain _____

List history of significant injuries, hospitalizations, surgeries

_____

_____

Does your child:	**Yes**	**No**	**If Yes, please explain**
a Have any unresolved physical pain or discomfort?	☐	☐	
STAFF ONLY: If "**yes**" to unresolved pain, explain referral			
b Currently have any infectious diseases such as MRSA, hepatitis, tuberculosis, meningitis, rubella, small pox, mumps, chicken pox, pneumonia, or any other?	☐	☐	
c Have special nutritional needs?	☐	☐	
d Experienced any recent weight gain or loss?	☐	☐	
e Has child been exposed to lice, scabies, bed bugs in past 3 months?	☐	☐	

Staff Recommendations: _____

Staff Signature _____ **Date Reviewed:** _____

By signing you are verifying that the information above has been reviewed and any identified needs for medical follow up, including the need for a physical examination, have been discussed and reviewed with the client and/or parent/guardian.