HEALTH SCREEN FORM

ORCHARD PLACE

Date: _____

Child's Name: _____Your Relationship to Child:_____Date of Birth:_____

Height:_____ Weight:_____ Date of Measurement: _____Gender:☐Male ☐Female

Height and Weight obtained from: ☐Medical Records(from PCP, PMIC, CGC, School Nurse, etc.) **OR** ☐OP Staff

If your child has a history of any of these health issues, please check and describe them below. This is not a complete list of conditions, signs or symptoms.

History of the following:	**Y**	**N**	**Description/Concern/Ability to Self-Manage**
1. Bones or Joints Bone or joint pain, arthritis, broken bones			
2. Brain or Neurological Seizures, tremors, paralysis, past trauma that is causing current concerns (concussion)			
3. Cancer			
4. Dental or Oral Health Any concerns, braces or retainers needed, loose teeth			Date of last exam:_____
5. Diabetes and last HbA1C (a lab that shows the average level of blood sugars over the previous three months and how well it has been controlled.)			
6. Ears or Hearing Any concerns, hearing aids needed, ringing in ears, tubes in ears			Date of last exam:_____
7. Eating, Digestion, or Bowel Change in or poor appetite, GERD (digestive disease that occurs when stomach acid or, bile flows back into your food pipe, the esophagus) or reflux, heartburn, nausea/vomiting, constipation, diarrhea, ulcers, laxative use, eating disorders, changes in stool			
8. Does your child have any special nutritional needs or is child at risk nutritionally? Has doctor prescribed vitamins or supplements? Starving self, binge eating, difficulty swallowing?			
9. Has child experienced any recent weight gain or loss? Are there concerns with child's height or weight?			
10. Allergies to food or medicine-Reaction?			
11. Unexplained Fever			
12. Eyes or Vision Any concerns, glasses or contacts needed			Date of last exam:_____
13. Reproductive System-Male or Female Any concerns related to periods (heavy, not having), pregnancies, sexually active, use birth control			
14. Headaches, Stomachaches, or Other Pains			
15. Heart, Blood, Circulatory System Irregular heart beat, dizziness, fatigue with activity, chest pain, tingling/numbness in extremities, treatment for any blood disorder (anemia), blood transfusions ☐Hypertension (High Blood Pressure) ☐Heart Disease (Diagnosis of Heart Condition)			
16. Infectious Disease (MRSA, hepatitis, meningitis, rubella, small pox, whooping cough, mumps, chicken pox, pneumonia, etc) ☐Hepatitis C ☐HIV/AIDS			
17. Immunizations- up to date on immunizations?			Seasonal flu immunization? Date: _____
18. Motor Skills, Coordination, or Mobility Does child have OT or PT? Use assistive device? Any trouble walking, sitting, or stiffness? Any difficulties with falls?			
19. Metabolic Syndrome (A cluster of risk factors that together, may lead to heart disease. Also known as Dysmetabolic Syndrome or Syndrome X)			

Child's Name: _____ Date: _____

	History of the following:	Y	N	Description/Concern/Ability to Self-Manage
20.	Respiratory or Breathing Reoccurring respiratory infections, reactive airway disease (asthma like symptoms: coughing, wheezing, shortness of breath)? Does child receive breathing treatments/nebulizer treatments (nebs)/use an inhaler? ☐Asthma (Does child have rescue inhaler? How often is it used?) ☐Chronic Obstructive Pulmonary Disease (COPD)			
21.	Sensorimotor (e.g., Over/Under reacts to sound, light, touch, etc)			
22.	Skin or Hair Rashes, hives, loss of hair, sores that won't heal, burns, itching, cuts, bruises, moist/sweaty skin, unusually cool skin, acne			
23.	Sleep or Rest Does child have difficulty falling or staying asleep? Experience sleep apnea or take sleeping pills? Have excessive fatigue?			
24.	Urinary or Bladder Does child experience burning, increased frequency, dribbling, incontinence, unable to hold urine or empty bladder, wetting (daytime or nighttime), is there a strong odor to urine?			
25.	Exposure to lice, scabies, bed bugs in past 3 months? If yes, which one and when? Treatment Used? Date completed?			
26.	Does child use caffeine? (pop or coffee) If yes, frequency and amount.			
27.	Does child use tobacco/substance abuse (Alcohol, Illegal drugs) If yes, frequency and amount.			
28.	Is child exposed to second hand smoke?			
29.	Is child experiencing any unresolved physical pain?			If yes, was a referral made? ☐ yes ☐ no (explain)
30.	Past medical procedures			
31.	Recent Hospitalization dates and reasons: Mental or Physical health admissions			
32.	Date of last physical examination: Example:School Physical/Annual Physical			
33.	ADHD/ Has child been prescribed a new ADHD medication in last 3 months?			If yes, list date prescribed and date of follow up appointment:
34.	Mental Health Diagnoses:			

Therapist/Nurse/BHIS Staff Recommendations:_____

Staff Signature: _____

IHP/Campus Nurse Signature:_____ Date Reviewed: _____

Child's Medication List

Please identify all medications including birth control as well as supplements

Prescription and OTC Medication & Dosage	What is the medication prescribed for?