

USD 320  
Wamego, Kansas  
Child Health Assessment

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Vision Screening:**

Date: \_\_\_\_\_ Wear Galses: Yes No  
Acuity: Rt: 20/ \_\_\_\_\_ Lt: 20/ \_\_\_\_\_ Both: 20/ \_\_\_\_\_  
Depth: Pass Fail  
Worth 4 Dot: Pass Fail  
Color: Pass Fail  
Corneal Light Reflex: Pass Fail  
Near Point Convergence: Pass Fail  
Plus Lens: Pass Fail

**Developmental Screening:**

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

**Hearing Screening:**

Date: \_\_\_\_\_  
ANSI 500 1000 2000 4000 6000  
Right \_\_\_\_\_  
Left \_\_\_\_\_  
Tympanometry:  
Right Pass Fail  
Left Pass Fail

**Speech Screening:**

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

**Vital Signs:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

**Physical Examination:**

General Appearance: \_\_\_\_\_

Skin: \_\_\_\_\_

Head/Neck: \_\_\_\_\_

EENT: \_\_\_\_\_

Oral/Dental: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_

Lungs: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Genitourinary: \_\_\_\_\_

Neurological: \_\_\_\_\_

**SIGNIFICANT ASSESSMENT FINDINGS:**

**RECOMMENDATIONS (INCLUDE ANY SPECIAL SCHOOL NEEDS):**

**CLEARED FOR ALL ACTIVITIES: YES NO**

**DOES THIS CHILD REQUIRE MEDICATION AT SCHOOL: YES NO**

**(If yes, a medication permission form is needed)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of physician or nurse approved to perform health assessments