

# INFANT, CHILD AND ADOLESCENT HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1994			
PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program. ROUTINE USES: No information is disclosed outside DOD. DISCLOSURE: Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.			
NAME OF SPONSOR	DEROS	TELEPHONE (HOME)	TELEPHONE (DUTY)
SPONSOR UNIT ADDRESS	SPONSOR SSN	SPOUSE'S WORK PHONE	
CHILD HEALTH INFORMATION (SPONSOR)			
NAME OF CHILD	BIRTH DATE	SEX	
HAS YOUR CHILD BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES EXPLAIN CIRCUMSTANCES AND CURRENT STATUS)			
IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM NO / YES LAST UPDATE:			

## PLEASE ATTACH COPY OF IMMUNIZATIONS

MEDICAL HISTORY					
		YES	NO	YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS				14. HEAT STROKE OR EXHAUSTION	
2. ALLERGIES TO MEDICINE OR INSECT BITES				15. BROKEN BONES OR SPRAINS	
3. SPEECH OR DEVELOPMENTAL DELAYS				16. JOINT INJURIES (ANKLE / KNEE / WRIST)	
4. VISION PROBLEMS (GLASSES / CONTACTS?)				17. REQUIRED RESTRICTED PHYSICAL ACTIVITY	
5. EAR OR HEARING PROBLEMS				18. FAMILY HISTORY OF DEATH LESS THAN AGE 40	
6. SEIZURES OR CONVULSIONS				19. FAMILY HX OF HEART DISEASE/STROKE < AGE 55	
7. DIZZINESS OR FAINTING WITH EXERCISE				20. FAMILY HX OF HIGH CHOLESTEROL	
8. HEADACHES				21. FAMILY HX OF CANCER	
9. HEAD INJURY OR LOSS OF CONSCIOUSNESS				22. DENTAL OR ORTHODONTIC BRACES	
10. NECK OR BACK INJURY				23. CHICKEN POX IF YES, DATE:	
11. ASTHMA OR DIFFICULTY BREATHING				24. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)	
12. HEART OR BLOOD PRESSURE PROBLEMS				25. FEMALES: AGE OF FIRST PERIOD:	
13. CHEST PAIN WITH EXERCISE				26. OTHER PROBLEMS (LIST BELOW):	
IF YOU ANSWER <u>YES</u> TO ANY OF THE ABOVE, PLEASE EXPLAIN:					
I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:				YES	NO
1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)					
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY					
3. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CDS/OTHER					
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS					
TYPED OR PRINTED NAME OF PARENT OR GUARDIAN			SIGNATURE OF PARENT OR GUARDIAN		

## MEDICAL STAFF ASSESSMENT (FILLED OUT BY PHYSICIAN ONLY)

AGE:	YRS	MOS	HEIGHT:	cm.(	%ile)	WEIGHT:	kgs.(	%ile)	BP:	/	P
			HEIGHT:	in.		WEIGHT:	lbs.				

VISUAL ACUITY: RIGHT	/LEFT	/TESTED WITH / WITHOUT LENSES	NORMAL	ABNORMAL	COMMENTS
1. EYES					
2. EARS, NOSE & THROAT					
3. HEARING					
4. MOUTH AND TEETH					
5. NECK (SOFT TISSUES)					
6. CARDIOVASCULAR					
7. CHEST AND LUNGS					
8. ABDOMEN					
9. GENITALIA - HERNIA					
10. SKIN AND LYMPHATICS					
11. NECK					
12. SPINE - SCOLIOSIS					
13. EXTREMITES					
14. NEUROLOGICAL					

15. SEXUAL MATURITY RATING: BREASTS >      PUBIC HAIR >      MALE GENITAL >      FEMALE GENITAL >

BASED ON THIS HX & PX EXAM, THE FOLLOWING ABORNALITIES WERE FOUND AND MAY NEED TREATMENT:

  
  
  
  

### ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)

NUTRITION	DENTAL CARE	HEADSS	
AGE APPROPRIATE SAFETY	BEHAVIOR		
DEVELOPMENT	RISK FACTORS		

### PARTICIPATION RECOMMENDATIONS

<input type="checkbox"/> NORMAL SCHOOL ACTIVITIES INCLUDING PE <input type="checkbox"/> CHILD DEVELOPMENT / YOUTH SERVICES <input type="checkbox"/> COLLISION SPORTS	<input type="checkbox"/> CONTACT SPORTS <input type="checkbox"/> NON-CONTACT SPORTS <input type="checkbox"/> SCOUTS
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THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

NO

YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

  
  

THIS DOCUMENT IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE	PHYSICIAN STAMP	PHYSICIAN SIGNATURE
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