Adriel Initial Youth Health Screening

Date:	Name: ☐ Male ☐ Female		
DOB:	Age:	Weight:	Height:
Temp:	BP:	Pulse:	Respiratory:

Does Child have any allergies: ☐ Yes ☐ No ☐ Unknown

Is Child taking any medications: ☐ Yes ☐ No ☐ Unknown Include Name, Dose and Administration Schedule:

Dates of Last:

Physical: ☐ Unknown	**Dental:** ☐ Unknown	**Optical:** ☐ Unknown	**Other:**

If no problem noted, please check normal. If problem noted, please explain.

	Normal	Problem
Head/Scalp		
E.N.T		
Lungs		
Skin		

Chronic Health Problems? ☐ Yes ☐ No If yes, please explain:

Mental Health

Mental health history or other pertinent information *(mental health concerns, suicidal ideation, suicidal attemts, behavior problems, dangerous or self desctructive behavior, psychotic behavior)* :

Recommendations:

☐ No Concerns Identified

☐ Minor Concerns Indentified ☐ Call Physician If Changes in Health Status OR ☐ Have Child Seen By Physician Within ____ Days

☐ Visible Signs/Symptoms of Trauma/Illness Require Immediate Medical Attention

☐ Advice / Treatments / Comments: ______________________________

Lice / Nits Present Upon Exam? ☐ Yes ☐ No

Nurses Signature: ______________________________ Date: __________

Health Screen was completed within 72 hours of placement: ☐ Yes ☐ No

If no, was Health Screen completed within 5 days of placement: ☐ Yes ☐ No