Adriel Initial Youth Health Screening

Date:	Name:		
DOB:	Age:	Weight:	Height:
Temp:	BP:	Pulse:	Respiratory:

Does Child have any allergies:

Is Child taking any medications: Include Name, Dose and Administration Schedule:

Dates of Last: **Physical:**	**Dental:**	**Optical:**	**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 history or other pertinent information *(mental health concerns, suicidal ideation, suicidal attemts, behavior problems, dangerous or self desctructive behavior, psychotic behavior)*:

Health conditions that require immediate or prompt medical attention? Yes / No If yes, please explain:

Health conditions that should be considered in making placement decisions? Yes / No If yes, please explain:

For children under 6 years old, is there a need for a developmental screening? Yes / No If yes, please explain:

Additional Recommendations:

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 / N/A*