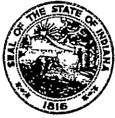

INSTRUCTIONS FOR USE OF HEALTH EVALUATION CHECKLIST

State Form 49965 (R / 5-09) / BCC 0060

At the time of admission of a child, the attached health evaluation checklist shall be completed by a caregiver.

PART I (2-10-66) (2-13-64)

If the answer to item one or two is yes and the child has not been seen by a physician for the abuse, the child shall be referred to a physician for examination immediately.

PART II

1. If child is not alert, seek medical consultation immediately.
2. Note all allergies, etc. and inform the physician as needed.
3. If child has been exposed to or has symptoms of a communicable disease, report to consulting physician within 48 hours.
4. If child has a continuing health condition, obtain a physical examination by a physician within 48 hours. (*Such conditions may include but are not limited to: asthma, diabetes, kidney or heart conditions, seizures, etc.*)
5. Note all items on child's record and note if items are brought with child. When needed, obtain instructions for use from appropriate person (*i.e., physician, dentist, therapist*).
6. If child is taking prescribed medications, report to consulting physician within 48 hours.
7. If continued use of over-the-counter medication is needed, consult with physician.
8. Note all responses in detail. Inform the physician as needed.
9. Same as number 8.
10. If child is in pain, refer to physician for evaluation.
11. Note information on record. Refer for medical follow-up when needed based on observed signs and symptoms.
12. Same as number 12.
13. If pregnancy is suspected, refer for medical evaluation within 48 hours.
14. If response is yes, refer for medical evaluation within 48 hours.
15. Refer for follow-up when needed.

PART III

Make a visual inspection of the child with his / her clothes on.

Note any unusual observations in specific detail.

* **Explain all yes responses. All yes responses must be reported to physician within 48 hours to determine if medical evaluation is needed.**

If child appears very ill, is in severe pain, or has very high temperature then he / she must be seen by a physician immediately. When in doubt regarding child's condition, always seek medical consultation.

List all referrals / follow-ups needed.

Complete the form with full name and signature of person making the assessment. Note the date and time the checklist is completed and the time the child is admitted to the facility.

* **If more space is needed, use the back of the form or attach a page.**

HEALTH EVALUATION CHECKLIST

State Form 49965 (R / 5-09) / BCC 0060

Name of child

PART I ABUSE ASSESSMENT:

☐ Yes ☐ No 1. Have you been physically abused?
If yes, when? ______
☐ Yes ☐ No Were you seen by a physician for this?
☐ Yes ☐ No 2. Have you been sexually abused?
If yes, when? ______
☐ Yes ☐ No Were you seen by a physician for this?

PART II MEDICAL QUESTIONS:

☐ Yes ☐ No 1. Is the child alert and oriented to time, place and name? (*If no, seek medical consultation*)
☐ Yes ☐ No 2. Do you have any allergies? (*Bee stings, food, plants, animals, medications, etc.*)
If yes, what? ______
☐ Yes ☐ No 3. Have you been exposed to any communicable diseases recently?
If yes, what? ______ When? ______
☐ Yes ☐ No 4. Do you have any chronic health conditions that require constant therapy?
If yes, what? ______
☐ Yes ☐ No 5. Do you use glasses / contacts, hearing aids, artificial limbs, body braces, dental appliances, removable teeth, etc.?
If yes, what? ______
☐ Yes ☐ No 6. Are you taking prescription medication?
If yes, what? ______ Reason: ______
☐ Yes ☐ No Is this medication with you?
☐ Yes ☐ No 7. Are you taking any over-the-counter medications?
If yes, what? ______ Why? ______ How often: ______
☐ Yes ☐ No 8. Do you use alcoholic beverages?
If yes, how much? ______
How often? ______ Last use: ______
☐ Yes ☐ No 9. Are you using street drugs?
If yes, what? ______
How often? ______ Last use: ______
☐ Yes ☐ No 10. Are you in any physical pain or discomfort now?
If yes, explain where: ______
______
☐ Yes ☐ No 11. When was the last time you saw a physician? ______
Reason: ______
☐ Yes ☐ No 12. When was the last time you saw a dentist? ______
Reason: ______
☐ Yes ☐ No 13. For girls, when was your last menstrual period?
☐ Yes ☐ No 14. Do you have any genital sores, unusual conditions or discharge?
☐ Yes ☐ No 15. Have you had surgery or a serious injury recently? If yes, explain: ______
______

PART III VISUAL INSPECTION: (*Child fully clothed*)

1. Skin:
☐ Yes ☐ No Needle marks
☐ Yes ☐ No Infected toe / fingernails
☐ Yes ☐ No Open wounds
☐ Yes ☐ No Infected cuts / scratches
☐ Yes ☐ No Rash
☐ Yes ☐ No Bruises
Other: ______

2. Eyes:
☐ Yes ☐ No Mucous discharge
☐ Yes ☐ No Watery
☐ Yes ☐ No Pink or red
☐ Yes ☐ No Lids crusty
☐ Yes ☐ No Stys or lesions on lids
Other: ______

(*Continued on reverse side.*)

PART III VISUAL INSPECTION (*continued*): (*Child fully clothed*)

3. Ears:
   - ☐ Yes ☐ No Drainage
   - Other: ____________________

4. Nose and Mouth:
   - ☐ Yes ☐ No Discharge from nose
   - Coughing
   - Neck swelling
   - Bleeding gums
   - Mouth or lip sores
   - Damaged teeth
   - Other: ____________________

5. Hair / Scalp:
   - ☐ Yes ☐ No Hair loss
   - Head lice
   - Ringworm
   - Other: ____________________

6. Temperature: ____________
   - ☐ Yes ☐ No Normal (98.6 degrees)
   - ☐ Yes ☐ No 100 degrees or above
   - ☐ Yes ☐ No 97 degrees or below and other symptoms

7. Height: ____________ Weight: ____________

8. List any other abnormalities noted: ____________________

9. Explain in detail all yes answers:

10. ☐ Yes ☐ No Medical or dental referral needed?
    If yes, explain: ____________________

Printed name of Assessor		Signature of Assessor
Date (*month, day, year*)	Time assessment done:	Time admitted: