New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
CHILDHOOD: 6 Years

DATE: ______________________

Child's Name		Date of Birth
Allergies	Illnesses/Injuries/Problems/Concerns	Current Medications

RN:

SUBJECTIVE

Y N
- ☐ ☐ My child eats a variety of foods
- ☐ ☐ My child can play make believe
- ☐ ☐ My child can count
- ☐ ☐ My child seems rested when he/she awakens
- ☐ ☐ My child knows right from left
- ☐ ☐ My child gets some physical activity every day

Diet: ______________________

- ☐ Vitamin Supplements
- ☐ Dental Referral
- ☐ Fluoride Supplements
- ☐ Hgb/Hct
- ☐ Lead Risk Assessment (verbal)
- ☐ Review Immunization Record
- ☐ TB Test (if high risk factor present)
- ☐ Cholesterol Screening (high risk children)

Elimination: ______________________

Sleep: ______________________

Other: ______________________

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

- ☐ Nutrition
- ☐ Development Benchmarks
- ☐ Regular Physical Activities
- ☐ Car Seat or Booster Seat
- ☐ Safety (general)
- ☐ Lead Poisoning Prevention
- ☐ Passive Smoke
- ☐ Oral Health Care
- ☐ Adequate Sleep/Habits
- ☐ Discipline/Limits
- ☐ School Readiness
- ☐ Limit TV
- ☐ Helmets

OBJECTIVE: SCREENING

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/IN PERCENTILE:	BLOOD PRESSURE:

	N	A	
Hearing	☐	☐	______________
Vision	☐	☐	______________
Development	☐	☐	______________
Behavior	☐	☐	______________
Social/Emotional	☐	☐	______________

APN/PA/MD/DO:

SUBJECTIVE

☐ Review of Family History

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☐ Review of Systems

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OBJECTIVE: PHYSICAL

	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Dental Structure/Tongue	☐	☐	Neurological	☐	☐
Mental Health	☐	☐			

ASSESSMENT (Problem List)

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PLAN

____

REFERRALS

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APN/PA/MD/DO SIGNATURE:

RN ASSESSMENT:	RN PLAN:	REFERRALS:
RN SIGNATURE:		

NEXT VISIT: 7 YEARS OF AGE

IMMUNIZATIONS: ☐ Given ☐ Up to date

ADDITIONAL NOTES