**New Jersey Department of Health**
**CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT**
**CHILDHOOD: 7 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 plays well with other kids |
| ☐ | ☐ | 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
- ☐ Fluoride Supplements
- ☐ Cholesterol Screening (high risk children)
- ☐ Review Immunization Record
- ☐ TB Test (if high risk factor present)
- ☐ Dental Referral

Elimination: _____

Sleep: _____

Other: _____

### HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

- ☐ Nutrition
- ☐ Development Benchmarks
- ☐ Regular Physical Activities
- ☐ Booster or Seat Belt
- ☐ 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

_____
_____
_____
_____
_____

☐ Review of Systems

_____
_____
_____
_____
_____

### 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)

_____
_____

### PLAN

_____
_____
_____

### REFERRALS

_____
_____

### APN/PA/MD/DO SIGNATURE:

| RN ASSESSMENT: | RN PLAN: | REFERRALS: |
|---|---|---|
| | | |

**RN SIGNATURE:**

**NEXT VISIT: 8 YEARS OF AGE**

**IMMUNIZATIONS:** ☐ Given ☐ Up to date



Additional notes on reverse side➔

## ADDITIONAL NOTES