# CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT

## CHILDHOOD: 9 Years

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date</th>
<th>Allergies</th>
<th>Illnesses/Injuries/Problems/Concerns</th>
<th>Current Medications</th>
</tr>
</thead>
<tbody>
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### SUBJECTIVE

**RN:**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>My child eats breakfast every day</th>
<th>My child is doing well in school</th>
<th>My child has one or more close friends</th>
<th>My child seems rested when he/she awakens</th>
<th>My child handles stress, anger and frustration appropriately</th>
<th>My child gets some physical activity every day</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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</table>

**APN/PA/MD/DO:**

- Review of Family History
- Review of Systems

### OBJECTIVE: PHYSICAL

**N/A**

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

### ASSESSMENT (Problem List)

<table>
<thead>
<tr>
<th>Health Education/Anticipatory Guidance: (Check All Completed)</th>
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<tbody>
<tr>
<td>Nutrition</td>
</tr>
<tr>
<td>Oral Health Care</td>
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</tbody>
</table>

### OBJECTIVE: SCREENING

**N/A**

- Weight
- Height
- Blood Pressure

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Vision</th>
<th>Development</th>
<th>Behavior</th>
<th>Social/Emotional</th>
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### PLAN

**REFERRALS**

<table>
<thead>
<tr>
<th>APN/PA/MD/DO SIGNATURE:</th>
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**REFERENCES**

**IMMUNIZATIONS:**

- Given
- Up to date

**NEXT VISIT: 10-12 YEARS OF AGE**

**ADDITIONAL NOTES ON REVERSE SIDE**

(Adapted from EPSDT form: DHS DMAHS/OQT/NJ HMOs)