New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
CHILDHOOD: 16-20 Years

DATE: _____

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

RN:

SUBJECTIVE

Y	N	
☐	☐	I eat breakfast every day
☐	☐	I have someone I can talk to
☐	☐	I have questions about sexuality
☐	☐	I am happy with how I am doing in school and/or work
☐	☐	I get some physical activity every day
☐	☐	I get enough sleep; _____ hours per night

Diet: _____

- ☐ Vitamin Supplements
- ☐ Fluoride Supplements
- ☐ Dental Referral
- ☐ Review Immunization Record
- ☐ Cholesterol Screening (high risk children)
- ☐ TB Test (if high risk factor present)

Elimination: _____
Sleep: _____
Other: _____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

☐ Nutrition/Weight Control	☐ Oral Health Care
☐ Smoking /Tobacco Use	☐ Injury Prevention/Safety
☐ Sex Education/Birth Control	☐ Sleep Patterns
☐ Driving and Alcohol	☐ Seat Belts
☐ Self Exam	☐ Drugs/Alcohol
☐ STD Discussed	☐ HIV/AIDS Discussed
☐ Regular Activity	☐ Suicide/Depression
☐ School Plans	☐ Work
☐ Peer Pressure	

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:

IMMUNIZATIONS: ☐ Given ☐ Up to date

Additional notes on reverse side➔

ADDITIONAL NOTES