

**New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
CHILDHOOD: 9 Years**

DATE: _____

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

RN:	APN/PA/MD/DO:
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SUBJECTIVE

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My child eats breakfast every day

My child is doing well in school

My child has one or more close friends

My child seems rested when he/she awakens

My child handles stress, anger and frustration appropriately

My child gets some physical activity every day

Diet: _____

Vitamin Supplements Menarche

Fluoride Supplements Hgb/Hct

Review Immunization Record Dental Referral

TB Test (if high risk factor present)

Cholesterol Screening (high risk children)

Elimination: _____

Sleep: _____

Other: _____

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

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Development	<input type="checkbox"/> Parenting Issues
<input type="checkbox"/> Regular Physical Activities	<input type="checkbox"/> Child Care Issues
<input type="checkbox"/> Seat Belt	<input type="checkbox"/> Adequate Sleep
<input type="checkbox"/> Safety (general)	<input type="checkbox"/> Helmets
<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> School Issues
<input type="checkbox"/> Limit TV	<input type="checkbox"/> Firearm Safety
<input type="checkbox"/> Menarche	<input type="checkbox"/> Drug, Alcohol
<input type="checkbox"/> Sexual Behavior	

SUBJECTIVE

Review of Family History

Review of Systems

OBJECTIVE: PHYSICAL

	N	A		N	A
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Dental Structure/Tongue	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>			

ASSESSMENT (Problem List)

OBJECTIVE: SCREENING

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/IN PERCENTILE:	BLOOD PRESSURE:
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	N	A	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Development	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLAN

REFERRALS

APN/PA/MD/DO SIGNATURE:

RN ASSESSMENT:	RN PLAN:	REFERRALS:
RN SIGNATURE:		

NEXT VISIT: 10-12 YEARS OF AGE	IMMUNIZATIONS: <input type="checkbox"/> Given <input type="checkbox"/> Up to date
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