

**New Jersey Department of Health and Senior Services  
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT  
CHILDHOOD: 6 Years**

DATE: \_\_\_\_\_

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

<b>RN:</b>	<b>APN/PA/MD/DO:</b>																																																																											
<p><b>SUBJECTIVE</b></p> <p><b>Y N</b></p> <p><input type="checkbox"/> <input type="checkbox"/> My child eats a variety of foods</p> <p><input type="checkbox"/> <input type="checkbox"/> My child can play make believe</p> <p><input type="checkbox"/> <input type="checkbox"/> My child can count</p> <p><input type="checkbox"/> <input type="checkbox"/> My child seems rested when he/she awakens</p> <p><input type="checkbox"/> <input type="checkbox"/> My child knows right from left</p> <p><input type="checkbox"/> <input type="checkbox"/> My child gets some physical activity every day</p> <p>Diet: _____</p> <p><input type="checkbox"/> Vitamin Supplements                      <input type="checkbox"/> Dental Referral</p> <p><input type="checkbox"/> Fluoride Supplements                      <input type="checkbox"/> Hgb/Hct</p> <p><input type="checkbox"/> Lead Risk Assessment (verbal)</p> <p><input type="checkbox"/> Review Immunization Record</p> <p><input type="checkbox"/> TB Test (if high risk factor present)</p> <p><input type="checkbox"/> Cholesterol Screening (high risk children)</p> <p>Elimination: _____</p> <p>Sleep: _____</p> <p>Other: _____</p> <p><b>HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Nutrition</td> <td><input type="checkbox"/> Oral Health Care</td> </tr> <tr> <td><input type="checkbox"/> Development Benchmarks</td> <td><input type="checkbox"/> Adequate Sleep/Habits</td> </tr> <tr> <td><input type="checkbox"/> Regular Physical Activities</td> <td><input type="checkbox"/> Discipline/Limits</td> </tr> <tr> <td><input type="checkbox"/> Car Seat or Booster Seat</td> <td><input type="checkbox"/> School Readiness</td> </tr> <tr> <td><input type="checkbox"/> Safety (general)</td> <td><input type="checkbox"/> Limit TV</td> </tr> <tr> <td><input type="checkbox"/> Lead Poisoning Prevention</td> <td><input type="checkbox"/> Helmets</td> </tr> <tr> <td><input type="checkbox"/> Passive Smoke</td> <td></td> </tr> </table> <p><b>OBJECTIVE: SCREENING</b></p> <table style="width:100%;"> <tr> <td style="width:33%;">WEIGHT KG/LB PERCENTILE:</td> <td style="width:33%;">HEIGHT CM/IN PERCENTILE:</td> <td style="width:33%;">BLOOD PRESSURE:</td> </tr> </table> <table style="width:100%;"> <tr> <td></td> <td style="text-align:center;"><b>N A</b></td> <td></td> </tr> <tr> <td>Hearing</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Vision</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Development</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Behavior</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td>Social/Emotional</td> <td style="text-align:center;"><input type="checkbox"/> <input 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type="checkbox"/>	_____	<p><b>SUBJECTIVE</b></p> <p><input type="checkbox"/> Review of Family History</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Review of Systems</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>OBJECTIVE: PHYSICAL</b></p> <table style="width:100%;"> <tr> <td></td> <td style="text-align:center;"><b>N A</b></td> <td></td> <td style="text-align:center;"><b>N A</b></td> </tr> <tr> <td>General Appearance</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Chest</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Head</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Cardiovascular/Pulses</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Eyes</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Ears</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Genitalia</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Nose</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Spine</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Oropharynx/Teeth</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> 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<b>RN ASSESSMENT:</b>	<b>RN PLAN:</b>	<b>REFERRALS:</b>
<b>RN SIGNATURE:</b>		
<b>NEXT VISIT: 7 YEARS OF AGE</b>		<b>IMMUNIZATIONS:</b> <input type="checkbox"/> Given <input type="checkbox"/> Up to date

