New Jersey Department of Health
CHILD HEALTH CONFERENCE – HEALTH ASSESSMENT
CHILDHOOD: 8 Years

DATE: _____

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

RN:

SUBJECTIVE

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

Elimination: _____
Sleep: _____
Other: _____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE: (CHECK ALL COMPLETED)

☐ Nutrition	☐ Oral Health Care
☐ Development	☐ Parenting Issues
☐ Regular Physical Activities	☐ Child Care Issues
☐ Seat Belt	☐ Adequate Sleep
☐ Safety (general)	☐ Helmets
☐ Passive Smoke	☐ School Issues
☐ Limit TV	

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: 9 YEARS OF AGE

IMMUNIZATIONS: ☐ Given ☐ Up to date

Additional notes on reverse side➔

ADDITIONAL NOTES