Child and Youth Development Center-TZ0605
In Cooperation with Compassion International Tanzania

Health Assessment Form

Child's Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female
- **Child ID Number:** _____
- **Date of Assessment:** _____
- **Age:** _____

Parent/Guardian Information

- **Name of Parent/Guardian:** _____
- **Relationship to Child:** _____
- **Contact Number:** _____
- **Address:** _____
- **Emergency Contact:** _____
- **Emergency Contact Number:** _____

Health History

- **Does the child have any known chronic illnesses?**
  ☐ Yes ☐ No ○ If yes, please specify:

  _____
- **Has the child had any recent illnesses or injuries?**
  ☐ Yes ☐ No ○ If yes, please describe:

  _____
- **Is the child currently on any medication?**

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☐ Yes ☐ No ○ If yes, please list medications:

_____

- **Has the child been hospitalized in the past year?**
  ☐ Yes ☐ No ○ If yes, please provide details:

  _____
- **Does the child have any allergies?**
  ☐ Yes ☐ No ○ If yes, please list allergies:

  _____
- **Immunizations:**
  ☐ Up-to-date ☐ Not up-to-date ○ Please specify any missing

  immunizations: _____

Nutritional Information

- **Child's Weight:** _____ •
  Child's Height: _____
- **Is the child currently receiving adequate nutrition?**
  ☐ Yes ☐ No
  - If no, please describe concerns: _____
- **Does the child have any special dietary needs?**
  ☐ Yes ☐ No
  - If yes, please specify: _____

Developmental and Behavioral Information

- **Has the child met developmental milestones for their age?**
  ☐ Yes ☐ No ○ If no, please describe concerns:

  _____
- **Are there any concerns regarding the child's behavior or emotional well-being?**

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☐ Yes ☐ No ○ If yes, please specify:

_____

- **Is the child currently receiving any psychological or counseling support?**
  ☐ Yes ☐ No
  - If yes, please provide details: _____

Physical Examination

- **General Appearance:** _____
- **Head, Eyes, Ears, Nose, Throat:** _____
- **Heart:** _____
- **Lungs:** _____
- **Abdomen:** _____
- **Extremities:** _____
- **Skin:** _____
- **Neurological:** _____

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Health Recommendations

- **Are there any health interventions or treatments recommended for this child?**
  ☐ Yes ☐ No ○ If yes, please describe:

  _____
- **Does the child need a follow-up appointment?**
  ☐ Yes ☐ No ○ If yes, specify when:

  _____

Assessment Completed By

- **Name of Health Professional:** _____
- **Signature:** _____
- **Date:** _____

Consent

I, the undersigned, confirm that the information provided is accurate to the best of my knowledge and consent to the health assessment of my child.

- **Parent/Guardian Name:** _____
- **Signature:** _____
- **Date:** _____

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This form covers essential health information and ensures that the child or youth's health needs are met while they are in the care of the organization.

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