

NORTH CAROLINA KINDERGARTEN HEALTH ASSESSMENT REPORT

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

Personal Data **Please bring your child's shot records with you to this visit**

Please Print Clearly - See other side for more required information. Please present completed form to your child's school.

Child's Name _____
(Last) (First) (Middle)

Birth Date: ____ / ____ / 20 ____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Yes **No**
 Are you concerned about your child's health, weight, development or behavior?
 Does anyone in your family have a condition that has affected their health, weight, development or behavior? **(Please explain in the comments section)**
 Has your child been seen by a provider for any health, weight, development or behavior concern?
 Has your child had a dental exam by a dentist in the last 12 months?
 Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. Signature: _____ Date: _____

PARENT COMPLETE

Recommendations to School Personnel Based on Health Assessment

No Recommendations, Concerns or Needs Requesting School Follow Up

Medication

Child takes medicine for specific health conditions:

List medication(s): 1. _____ 3. _____
 2. _____ 4. _____

Medication must be given and/or available at school

Allergy

Food: _____ Insect: _____ Medicine: _____ Other: _____

Type of allergic reaction: Anaphylaxis Local reaction

Response required: Epinephrine Auto-injector Other: _____ None

Developmental Concerns Identified (See comments below)
 Child needs referral to school support team for further evaluation.

Special Diet
 Guidance: _____

Health-Related Recommendations to Enhance School Performance
For example: sitting near the front of classroom, special equipment needs.
 Please specify: _____

School Health Forms Attached

School Medication Authorization Form Diabetes Care Plan Asthma Action Plan
 Health Care Plan(s) List Condition _____

Comments: _____

HEALTH CARE PROVIDER COMPLETE

Was this assessment completed in the child's regular health care provider's office? yes no
if no, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification - Attach a copy of the immunization record.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: _____ Provider Stamp Here

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____

Personal Data

PARENT COMPLETE

Child's Birthdate: ____ / ____ / 20 ____ (mm/dd/yyyy) Race: 1 Other Non-White 5 Chinese 9 Other Asian
 Sex: 1 Male 2 Female 2 White 6 Japanese 10 Unknown
 County of Residence: _____ 3 Black 7 Hawaiian
 Zip Code: _____ 4 American Indian 8 Filipino
 School your child will be attending: _____ Hispanic or Latino Origin: 1 Yes 2 No
 Place where your child gets regular health care: _____ Child has:
 1 Health Department 4 Private Doctor/HMO 1 Medicaid 3 No Insurance
 2 Hospital Clinic 5 Other _____ 2 Private Insurance/HMO 4 Other: _____
 3 Community Health Center 6 No regular place **Doctor/Practice Name:** _____
Dentist Name: _____

Date of Health Assessment: ____ / ____ / ____

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations - Attach a copy of the immunization record.

Pertinent Illnesses, Risks or Developmental Problems: (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic Conditions |
| <input type="checkbox"/> Anemia <input type="checkbox"/> At-Risk for Anemia | <input type="checkbox"/> Emotional/Behavioral | <input type="checkbox"/> Prematurity (<32 wks. EGA) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Encopresis | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Attention/Learning | <input type="checkbox"/> Enuresis (Daytime) | <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Trait |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> At-Risk for TB |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Vision Disorders |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Conditions | <input type="checkbox"/> Lead (Hx of ≥ 10 mcg/dL) <input type="checkbox"/> At-Risk <input type="checkbox"/> Test done <input type="checkbox"/> None | |
| <input type="checkbox"/> Obesity | | |

Screening Results

Developmental	Screening Tool(s) Used: <input type="checkbox"/> 1 PEDS <input type="checkbox"/> 4 PSC <input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE	Developmental Domains: Emotional/Social Problem Solving Language/Communication Fine Motor Skills Gross Motor Skills	Within Normal: 1 Concern Identified: 2 Referred to Specialist: 3	Comments: _____ _____ _____												
Hearing	<table border="1"> <tr> <th>Hearing</th> <th>1000 Hz</th> <th>2000 Hz</th> <th>4000 Hz</th> </tr> <tr> <td>Right</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left</td> <td></td> <td></td> <td></td> </tr> </table>	Hearing	1000 Hz	2000 Hz	4000 Hz	Right				Left				Screening Tool Used: <input type="checkbox"/> 1 OAE <input type="checkbox"/> 2 Audiometry	<input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks. <input type="checkbox"/> 3 Referral to audiologist/ENT (check if yes) <input type="checkbox"/> 4 Child has previously diagnosed hearing loss. Screening is not necessary.	
	Hearing	1000 Hz	2000 Hz	4000 Hz												
Right																
Left																
Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.																
Vision	Please remember that vision screening is not a substitute for a comprehensive eye examination.			<input type="checkbox"/> 1 Pass (Acuity, Stereopsis, & Symptoms) <input type="checkbox"/> 2 Referral to eye doctor (check if YES) Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease. <input type="checkbox"/> 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.												
	<table border="1"> <tr> <td></td> <td>Right</td> <td>Left</td> <td>Stereopsis</td> <td><input type="checkbox"/> Pass <input type="checkbox"/> Fail</td> </tr> <tr> <td>Far:</td> <td>20/</td> <td>20/</td> <td>Acuity Test Used:</td> <td></td> </tr> </table> Was test performed with corrective lenses? <input type="checkbox"/> yes <input type="checkbox"/> no		Right		Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Far:	20/	20/	Acuity Test Used:					
	Right	Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail												
Far:	20/	20/	Acuity Test Used:													

Physical Examination

Weight: _____ lbs. Height: ____ ft. ____ in.

Body Mass Index (BMI) - for age: _____	HEENT	Normal	Abnormal
<input type="checkbox"/> 1 Underweight (< 5%ile)	Dental/Oral	1	2
<input type="checkbox"/> 2 Healthy Weight (5%ile to < 85%ile)	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 3 Overweight (85%ile to < 95%ile)	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 4 Obese (≥ 95 %ile)	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure: _____ / _____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1 Within Normal Range	Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 > 90 th Percentile (_____ %ile)	Genital	<input type="checkbox"/>	<input type="checkbox"/>
	Skin	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

HEALTH CARE PROVIDER COMPLETE