

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 **

PARENT COMPLETE

Please Print Clearly - See other side for more required information

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

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

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

Parent/Guardian Name: _____ Phone: _____

- | | | | | |
|--------------------------|------------|--------------------------|-----------|--|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | Are you concerned about your child's health, weight, development or behavior? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | Has your child been seen by a provider for any health, weight, development or behavior concern? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | Does anyone in your family have a condition that has affected their health, weight, development or behavior? (Please explain in the comments section) |
| <input type="checkbox"/> | | <input type="checkbox"/> | | Has your child had a dental exam by a dentist in the last 12 months? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | 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: _____

Recommendations to School Personnel Based on Health Assessment

HEALTH CARE PROVIDER COMPLETE

- 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: _____

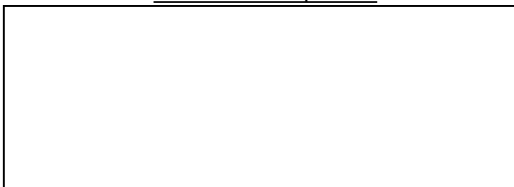
Was this assessment completed in the child's regular health care provider's office? yes no
If no, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification

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

Provider's Name: _____
 Provider's Signature: _____ Date: _____
 Practice/Clinic Name: _____
 Practice/Clinic Address: _____
 Practice/Clinic City, State & Zip: _____
 Practice Phone: _____ Fax: _____

Provider Stamp Here



Personal Data

PARENT COMPLETE

Child's Birthdate: ____/____/____ (mm/dd/yyyy) Race: 1 Other Non-White 5 Chinese 9 Other Asian
 Sex: Male 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 2 Private Insurance/HMO
 2 Hospital Clinic 5 Other _____ 3 No insurance 4 Other : _____
 3 Community Health Center 6 No regular place **Doctor/Practice 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 Problems |
| <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"/> Bleeding Problems | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> At-Risk for TB |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Lead (Hx of >10 mcg/dL) <input type="checkbox"/> At-Risk <input type="checkbox"/> Test done | <input type="checkbox"/> None |

Screening Results

Developmental	Screening Tool(s) Used:	Developmental Domains:	Within Normal	Concern Identified	Referred to Specialist	Comments:
	<input type="checkbox"/> 1 PEDS <input type="checkbox"/> 4 PSC <input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE <input type="checkbox"/> 3 IDI/CDI <input type="checkbox"/> 6 Brigance	Emotional/Social Problem Solving Language/Communication Fine Motor Skills Gross Motor Skills	1	2	3	

Hearing	Hearing	1000 Hz	2000 Hz	4000 Hz	Screening Tool Used:	<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.
	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 <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 or unable to test) <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.
		Both	Right	Left	
	Far:				Test Used:
	Was test performed with corrective lenses? <input type="checkbox"/> yes <input type="checkbox"/> no				

Physical Examination

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

Comments: _____

HEALTH CARE PROVIDER COMPLETE