

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. 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: _____

HEALTH CARE PROVIDER 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: _____

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

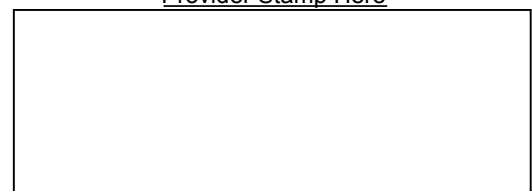
Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____



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
 Hispanic or Latino Origin: 1 Yes 2 No

School your child will be attending: _____ Child has:
 1 Medicaid 3 No Insurance
 2 Private Insurance/HMO 4 Other: _____

Place where your child gets regular health care:
 1 Health Department 4 Private Doctor/HMO **Doctor/Practice Name:** _____
 2 Hospital Clinic 5 Other _____ **Dentist Name:** _____
 3 Community Health Center 6 No regular place

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:		Developmental Domains:			Within Normal	Concern Identified	Referred to Specialist	Comments:
	<input type="checkbox"/> 1 PEDS	<input type="checkbox"/> 4 PSC	Emotional/Social	1	2	3			
Hearing	<input type="checkbox"/> 2 ASQ	<input type="checkbox"/> 5 ASQ-SE	Problem Solving						
			Language/Communication						
			Fine Motor Skills						
Vision	Hearing				Screening Tool Used:				
	1000 Hz	2000 Hz	4000 Hz		<input type="checkbox"/> 1 OAE	<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				<input type="checkbox"/> 2 Audiometry				
Left									
Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.									
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.				
	Right	Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail					
Far:	20/	20/	Acuity Test Used:						
Was test performed with corrective lenses? <input type="checkbox"/> yes <input type="checkbox"/> no									

Physical Examination

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

Body Mass Index (BMI) - for age: _____	Normal	Abnormal
<input type="checkbox"/> 1 Underweight (< 5%ile)	1	2
<input type="checkbox"/> 2 Healthy Weight (5%ile to < 85%ile)		
<input type="checkbox"/> 3 Overweight (85%ile to < 95%ile)		
<input type="checkbox"/> 4 Obese (≥ 95 %ile)		

Blood Pressure: _____ / _____

<input type="checkbox"/> 1 Within Normal Range	HEENT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 > 90 th Percentile (_____ %ile)	Dental/Oral	<input type="checkbox"/>	<input type="checkbox"/>
	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
	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