

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: / / 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. 2. 3. 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:

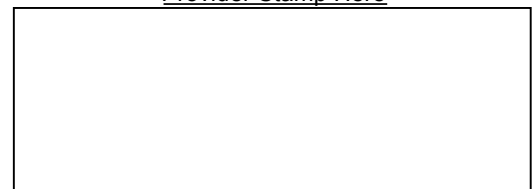
Was this assessment completed in the child's regular health care provider's office? yes no
If no, please provide a copy to the child's parent to give to the child's regular health care provider.

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

Provider Stamp Here



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 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)

- Allergy
- Anemia At-Risk for Anemia
- Asthma
- Attention/Learning
- Bleeding Problems
- Cancer/Leukemia
- Cerebral Palsy
- Cystic Fibrosis
- Dental Problems
- Diabetes
- Emotional/Behavioral
- Encopresis
- Enuresis (Daytime)
- Genetic Disorders
- Heart Problems
- Hearing Problems
- Kidney Problems
- Lead (Hx of >10 mcg/dL) At-Risk Test done
- Obesity
- Orthopedic Problems
- Prematurity (<32 wks. EGA)
- Seizures/Convulsions
- Sickle Cell Anemia Trait
- Speech/Language
- Tuberculosis At-Risk for TB
- Vision Problems
- Other: _____
- 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 CDI/CDR <input type="checkbox"/> 6 Brigance	Emotional/Social Problem Solving Language/Communication Fine Motor Skills Gross Motor Skills	1	2	3	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Hearing	Hearing	1000 Hz	2000 Hz	4000 Hz	Screening Tool Used:	Comments:
	Right				<input type="checkbox"/> 1 OAE <input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Audiometry <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.	
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.				Comments:
	Right	Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Far:			Acuity Test Used:		<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.
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: _____

- 1 Normal (5%ile - <85%ile)
- 2 Underweight (<5%ile)
- 3 At-Risk (85%ile to <95%ile)
- 4 Overweight (95%ile)

Blood Pressure: _____ / _____

- 1 Within Normal Range
- 2 > 90th Percentile (_____ %ile)

	Normal	Abnormal
	1	2
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
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