

# 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  
 Place where your child gets regular health care: \_\_\_\_\_  2 Private Insurance/HMO  4 Other: \_\_\_\_\_  
 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 $\geq 10$ 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 <input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE		1	2	3	
		Emotional/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Language/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Gross Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hearing	Hearing	1000 Hz	2000 Hz	4000 Hz	Screening Tool Used:	Comments:
	Right					
Left				<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.		

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:	20/	20/	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: _____	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"/>	<input type="checkbox"/>
<input type="checkbox"/> 3 Overweight (85%ile to < 95%ile)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 4 Obese ( $\geq 95$ %ile)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure: _____ / _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1 Within Normal Range	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 > 90 <sup>th</sup> Percentile ( _____ %ile)	<input type="checkbox"/>	<input type="checkbox"/>

HEENT    
 Dental/Oral    
 Lungs    
 Cardiac    
 Abdomen    
 Neurological    
 Back/Extremities    
 Genital    
 Skin

Comments: \_\_\_\_\_

HEALTH CARE PROVIDER COMPLETE