NASH/EDGECOMBE
PRE-KINDERGARTEN HEALTH ASSESSMENT REPORT

PARENT COMPLETE

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: _____ _____ _____ **Birth Date:** ____/____/ 20____ (mm/dd/yyyy)
(Last) (First) (Middle)

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

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: _____

_____

Parent/Guardian Name: _____ **Phone:** _____

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 medication for specific health conditions List Medications: 1. _____ 3. _____

☐ Medication must be given and/or available at school 2. _____ 4. _____

☐ **Allergy**

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

Type of allergic reaction: ☐ Anaphylaxis ☐ Local Reaction **Response Required:** ☐ Epinephrine Auto-Injector ☐ Other: _____ ☐ None

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

☐ **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. Complete ALL screenings.

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

Provider Stamp Here

Provider's Name: _____

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice Phone: _____ Fax: _____

PARENT

Personal Data

Child's Birth Date: ____/____/ 20____ (mm/dd/yyyy)

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

County of Residence: _____ **Zip Code:** _____

School your child will be attending: _____ **Sex:** ☐ 1 Male ☐ 2 Female **Hispanic or Latino Origin:** ☐ 1 Yes ☐ 2 No

Child has: ☐ 1 Medicaid ☐ 2 Private Insurance/HMO ☐ 3 No Insurance ☐ 4 Other: _____

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

Doctor/Practice Name: _____ **Dentist Name:** _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/____ - Assessment must be completed no more than 12 months prior to child's first day of Pre-K

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 Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of >10 mcg/dL) ☐ At-Risk ☐ Test Done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other:_____
☐ None

Screening Results – Screenings MUST be completed and scored for ALL children who may be enrolling in an NC Pre-K program.

Developmental

Screening Tool(s) Used: ☐ 1 PEDS ☐ 4 PSC ☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

_____

Hearing

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.

Screening Tool Used: ☐ 1 OAE ☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT **(check if YES)**
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis ☐ Pass ☐ Fail
Far:	20/	20/	Acuity Test Used:

Was test performed with corrective lenses? ☐ Yes ☐ No

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 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.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

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

Body Mass Index (BMI) – for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (>95%ile)

Blood Pressure: _____/_____
☐ 1 Within Normal Range
☐ 2 >90th percentile (_____%ile)

	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Comments: _____

_____

_____

_____