

**NORTH CAROLINA
KINDERGARTEN HEALTH ASSESSMENT REPORT**

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

Datos Personales *Favor de traer los records de las vacunas consigo a la visita*

LLENADO POR EL PADRE

Por Favor Escribe Claramente –Vea el otro lado para más info requerida

Nombre del Niño(a): _____
(Apellido) (Primer Nombre) (Segundo Nombre)

Fecha de Nacimiento: ____/____/____ (mes/día/año)

Dirección: _____ Ciudad _____ Estado: _____ Código Postal _____

Nombre del Padre/apoderado legal: _____ teléfono: _____

Si No

- ¿Hay algo sobre la salud general de su hijo(a) que le preocupa a usted, por ejemplo cuánto pesa, como está creciendo, o como se comporta?
- ¿Has llevado a su hijo(a) al doctor para alguno de estos problemas?
- ¿Hay alguien en la familia que tiene alguna condición que ha afectado su salud, peso, desarrollo o comportamiento? (favor de explicar en la sección abajo para comentarios)
- ¿Ha ido su hijo(a) al dentista en los últimos 12 meses?
- ¿Su hijo(a) ha tenido una visita de niño sano o un chequeo por un medico en los últimos 12 meses?

Comentarios: _____

Permiso del Padre: Yo estoy de acuerdo para que el médico de mi hijo(a) y el personal de la escuela hablen sobre la información en esta forma y doy permiso al Departamento de Salubridad y Servicios Humanos que coleccionen y analicen información en esta forma para tener mejor entendimiento sobre las necesidades de la salud de los niños de Carolina del Norte. Firma: _____ Fecha: _____

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 - 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

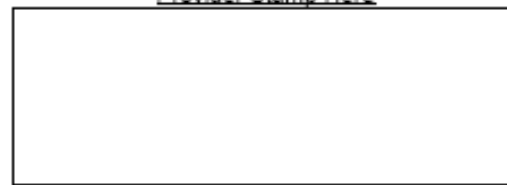
Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____



Datos Personales

LLENADO POR EL PADRE

Fecha de nacimiento del niño ____/____/____(mes/día/año) Raza: 1 Otro, no blanco 5 Chino 9 Otro asiático
 Sexo: Masculino Femenino 2 Blanco 6 Japones 10 Desconocido
 Condado de Residencia: _____ 3 Negro 7 Hawaiano
 4 Indio Americano 8 Filipino

Código Postal _____ De origen Hispano o Latino: 1 Si 2 No

La escuela donde asistirá su hijo(a) _____ Su hijo(a) tiene:
 1 Medicaid 2 Seguro Privado/HMO
 3 No tiene seguro 4 Otro: _____
 Lugar donde su hijo(a) recibe su cuidado de salud regular:
 1 Departamento de Salubridad 4 Médico Privado/HMO
 2 Hospital/Clinica 5 Otro: _____ **Nombre del Médico/Clinica:** _____
 3 Centro de Salud de la Comunidad 6 Ningún lugar regular

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"/> Trait |
| <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 _____ |
| <input type="checkbox"/> Obesity | | |

Screening Results

Developmental	Screening Tool(s) Used:	Developmental Domains:			Comments:
		Within Normal 1	Concern Identified 2	Referred to Specialist 3	
<input type="checkbox"/> 1 PEDS	<input type="checkbox"/> 4 PSC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 2 ASQ	<input type="checkbox"/> 5 ASQ-SE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> 3 CDI/CDR	<input type="checkbox"/> 6 Brigance	<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"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 (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:			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: _____

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