WAKE COUNTY
KINDERGARTEN HEALTH ASSESSMENT REPORT

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

Personal Data (*TO BE COMPLETED BY PARENT OR GUARDIAN*)

(Please Print Clearly)

Child's Name _____ _____ _____
(Last) (First) (Middle)

Birth Date: ___ / ___ / _____ (mm/dd/yyyy)

Address: _____ Phone: (___)_____

Parent/Guardian Name: _____

This assessment was completed by child's regular health care provider ____ yes ____ no. If no, *parent* please provide a copy to the child's regular health care provider.

Yes	No	
❑	❑	Do you have any concerns about your child's health, weight, development or behavior?
❑	❑	Has your child been evaluated for any health, weight, developmental or behavioral concerns?
❑	❑	Is there any family history of health, weight, developmental or social/emotional concerns?
❑	❑	Has your child had a dental exam by a dentist in the last 12 months?
❑	❑	Has your child had a well-child or preventive health exam in the last 12 months?

Comments: _____
_____
_____

Recommendations to School Personnel Based on Health Assessment (*TO BE COMPLETED BY HEALTH CARE PROFESSIONAL*)

___ **Activity Level.** Evaluate need to modify activity level. Guidance: _____

___ **Allergy** ❑ food: _____ ❑ insect: _____ ❑ medicine: _____ ❑ other: _____ ____
Type of allergic reaction: ❑ anaphylaxis ❑ local reaction
Response required: ❑ epi pen ❑ other: _____

___ **Developmental Evaluation.** Consider need for developmental evaluation. Guidance:_____

___ **Health-related adjustments to enhance school performance.** Evaluate need for adjustments.
Guidance: _____

___ **Medication**
___ Child takes medicine for specific health conditions:
List medication(s): 1. _____ 3 _____
2. _____ 4. _____
___ Medication must be given and/or available at school. **Requires School Medication Authorization form**.
___ School Medication Authorization Form complete (please **attach**)
___ Asthma Action Plan complete (please **attach**)

___ **Special Diet. Guidance:** _____

Comments: _____
_____
_____

Health Care Professional's Certification

I certify that the information on page 1 and page 2 of this form is accurate and complete.

Name Health Care Provider (**write legibly or stamp**): _____
Signature _____ Date: _____
Practice/Clinic Name & Address: _____
Phone Number: (___)_____ Fax Number: _____

Personal Data (*TO BE COMPLETED BY PARENT OR GUARDIAN*)

Child's Birthdate: ___ / __ / _____ (MM DD YYYY) Sex: ❑ 1 Male ❑ 2 Female

Race: ❑ 1 other non-White ❑ 2 White ❑ 3 Black ❑ 4 Am. Indian ❑ 5 Chinese ❑ 6 Japanese ❑ 7 Hawaiian ❑ 8 Filipino ❑ 9 Other Asian ❑ 10 Unknown

Hispanic/Latino origin: ❑ 1Yes ❑ 2 No

County of Residence: _____ Zip Code: _____ School your child will be attending: _____

Child has: ❑ 1 Medicaid ❑ 2 Private insurance/HMO ❑ 3 Other: _____ ❑ 4 No insurance

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: _____

Health Assessment (*TO BE COMPLETED BY HEALTH CARE PROFESSIONAL*)

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.

Date of Assessment: ___/___/___

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-95%ile)
- ❑ 4 Overweight (>95%ile)

Blood Pressure:

- ❑ 1 Within Normal Range
- ❑ 2 > 90th Percentile

_____ %ile

_____ (raw)

Physical Examination	Normal 1	Abnormal 2
HEENT	❑	❑
Dental/Oral	❑	❑
Lungs	❑	❑
Cardiac	❑	❑
Abdomen	❑	❑
Neurologic	❑	❑
Back/Extremities	❑	❑
Genital	❑	❑
Skin	❑	❑

Immunization Status (PROVIDE IMMUNIZATION RECORD– Form <u>will not be accepted</u> without record)

Immunizations are up-to-date ❑ 1 YES ❑ 2 NO

Pertinent Illnesses or Developmental Problems: *(Please check all that apply):*

- ❑ Allergy (specify in Recommendations above)
- ❑ Anemia
- ❑ Asthma
- ❑ Attention/Learning
- ❑ Bleeding Problems
- ❑ Cancer/Leukemia
- ❑ Cerebral Palsy
- ❑ Convulsions/Seizures
- ❑ Cystic Fibrosis
- ❑ Dental Problems
- ❑ Diabetes
- ❑ Emotional/Behavioral
- ❑ Encopresis
- ❑ Enuresis (daytime)
- ❑ Genetic Disorders
- ❑ Heart Problems
- ❑ Hearing Problems
- ❑ Lead (History of > 10 mcg/dL)
- ❑ Orthopedic Problems
- ❑ Prematurity (< 32 wks. EGA)
- ❑ Sickle Cell Anemia
- ❑ Speech/Language
- ❑ Vision Problems
- ❑ Other:
- ❑ none

Screening Results

Developmental

Tool Used:
PEDS 1 ❑
ASQ 2 ❑
IDI/CDI 3 ❑

	Within Normal Range 1	Concern Identified 2	Referred for Evaluation 3
Emotional/Social	❑	❑	❑
Problem Solving	❑	❑	❑
Language/Communication	❑	❑	❑
Fine Motor Skills	❑	❑	❑
Gross Motor Skills	❑	❑	❑

Hearing

Hearing		1000	2000	4000
	R			
	L			

Indicate Pass (P) or Refer (R) in each box. Refer is any failure at any frequency in either ear.

- ❑ With Hearing Aid (check if yes)
- ❑ Permanent Hearing Loss Previously Identified (check if yes)

Screen Used: ❑ 1 OAE ❑ 2 Audiometry

- ❑ 1 Pass
- ❑ 2 Scheduled for re-screen due to middle ear fluid. Date of rescreen appt: _____
- ❑ 3 Referral to Audiologist/ENT (check if yes)

Vision

Stereo: ❑ 1 Pass ❑ 2 Fail				Test used:
Far	Both	R	L	
	20/	20/	20/	Test used:
With Glasses: ❑ 1 Yes ❑ 2 No				

❑ 1 Pass

❑ 2 Referral to Eye Doctor (check if YES)

(Refer if worse than 20/40 in either of both eyes, a two line difference between eyes, failed stereo, or unable to test.)

Comments: _____

_____