PPS-2K Rev. 1/11

# NORTH CAROLINA
# KINDERGARTEN HEALTH ASSESSMENT REPORT

Evaluación de Salud de Niños en edad de Asistir al Kindergarten

(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

**Por favor, escriba claramente - Vea al dorso la información adicional requerida. Por favor, presente el formulario completado a la escuela de su niño/niña.**

Nombre del niño/niña ____________________ ____________________ ____________________

(Apellido) (Primer) (Segundo)

Fecha de nacimiento: ____/ ____/ 20____ (mm/dd/aaaa)

Dirección: ____________________ Ciudad: ____________ Estado: ____ Código postal: ________

Nombre del padre o tutor legal: ______________________________ Teléfono: ____________

| Si | No | |
|---|---|---|
| ☐ | ☐ | ¿Tiene alguna preocupación sobre la salud, peso, desarrollo o conducta de su niño? |
| ☐ | ☐ | ¿Sufre algún miembro de su familia alguna enfermedad que ha afectado su salud, peso, desarrollo o conducta? (Por favor, explíquelo en la sección de comentarios) |
| ☐ | ☐ | ¿Ha visto a su niño algún proveedor por alguna preocupación con su salud, peso, desarrollo o conducta? |
| ☐ | ☐ | ¿Ha tenido su niño una evaluación dental en los últimos 12 meses? |
| ☐ | ☐ | ¿Ha tenido su niño una consulta de salud con un médico en los últimos 12 meses? |

Comentarios: ______________________________________________

Consentimiento de los padres: Estoy de acuerdo con que el proveedor de atención médica y el personal de la escuela de mi niño conversen sobre la información de este formulario y permita que el Departamento de Salud y Servicios Humanos recolecten y analicen la información de este formulario para entender mejor las necesidades de salud de los niños en Carolina del Norte.

Firma: ______________________ Fecha: ________

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: ______________

## Personal Data



**PARENT COMPLETE**

Fecha de nacimiento del niño(a): ___/___/ 20___ (mm/dd/aaaa)

Sexo: ☐ 1 Masculino ☐ 2 Femenino

Condado de residencia: ____________________

Código postal: ____________________

Escuela a la que asistirá su niño/niña: ____________________

Lugar donde el niño/niña recibe su atención médica:

☐ 1 Departamento de Salud
☐ 2 Clínica del Hospital
☐ 3 Centro Comunitario de Salud
☐ 4 Médico Privado/Organización de Mantenimiento de la Salud (HMO)
☐ 5 Otro ____________
☐ 6 No usa un lugar en forma regular

Raza:
☐ 1 Otra Que No Sea Blanca
☐ 2 Blanca
☐ 3 Negra
☐ 4 Indígeno Americano
☐ 5 China
☐ 6 Japonesa
☐ 7 Hawaiana
☐ 8 Filipina
☐ 9 Otra Asiática
☐ 10 Desconocida

Origen Hispano o Latino: ☐ 1 Si ☐ 2 No

El niño/niña tiene:
☐ 1 Medicaid
☐ 2 Seguro Privado/HMO
☐ 3 Sin Seguro
☐ 4 Otro: ____________

***Nombre del Médico/Práctica:*** ____________________

***Nombre del Dentista:*** ____________________

**HEALTH CARE PROVIDER COMPLETE**

## 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 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
☐ Obese
☐ 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

### 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:** ____________________