PPS-2K Rev. 1/08

NORTH CAROLINA
KINDERGARTEN HEALTH ASSESSMENT REPORT

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

Datos Personales* *Por favor traiga el record de vacuna de su Niño*

PADRE COMPLETAR

Por Favor Escriba Claro

Nombre del Niño ____________________ ____________________
(Apellidos) (Nombre)

Fecha de Nacimiento:_____ / _____ / _____ (mm/dd/aaaa)

Dirección ____________________ Ciudad: __________ Estado: ______ Código Postal: ______

Nombre del Padre/Guardián: ____________________ Teléfono: __________

Si	No	
☐	☐	¿Está usted preocupado por la saludpeso, desarrollo o conducta de su niño?
☐	☐	¿Su niño ha sido evaluado por un doctor para cualquier problema de salud, peso, desarrollo o conducta?
☐	☐	¿Alguien en su famila ha tenido problemas de salud, peso, desarrollo o conducta? (Explique en la sección de comentarios)
☐	☐	¿Su niño tuvo un examen dental por el dentista en los últimos 12 meses?
☐	☐	¿Su niño tuvo una vista de chequeo al doctor en los últimos 12 meses?

Comentarios: ____________________

Consentimiento Paternal: Le doy permiso al Médico y at personal de la escuela a discutir información que contiene este formulario y permito al Departamento de Salud y Servicios Humanosa reunirse y analizar información para mejorar el desarrollo de las 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's Signature: ____________________ Date: __________

Practice/Clinic Name: ____________________

Practice/Clinic Address: ____________________

Practice/Clinic City, State & Zip: ____________________

Practice Phone: __________ Fax: __________

Provider Stamp Here

Personal Data Datos Personales

PADRES COMPLETAR

Fecha de Nacimiento del niño:_____ / ______/20______ (mm/dd/aaaa)

Sexo: ☐ Masculino ☐ Femenino

Condado de residencia: ______________________

Código Postal: ______________________

Escuela dónde que su hijo asiste: ______________________

Dónde su niño recibe asistencia médica:

☐ 1 Departmento de Salud ☐ 4 Médico Privado/ HMO

☐ 2 Hospital ☐ 5 Otro ____________

☐ 3 Centro Médico Comunitario ☐ 6 Ningun Lugar

Raza: ☐ 1 Otro no Blanco ☐ 5 Chino ☐ 9 Otro Asiático

☐ 2 Blanco ☐ 6 Japonés ☐ 10 Desconocido

☐ 3 Negro ☐ 7 Hawaiano

☐ 4 Indio Americano ☐ 8 Filipino

Hispano o Latino: ☐ 1 Sí ☐ 2 No

El Niño Tiene:

☐ 1 Medicaid ☐ 3 Seguro Privado/ HMO

☐ 2 No Seguro ☐ 4 Otro ____________

Nombre del Doctor/Clínica: ______________________

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

Screening Results

Developmental

Screening Tool(s) Used:

☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE
☐ 3 CDI/CDR ☐ 6 Brigance

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

Comments: ______________________