

KINDERGARTEN HEALTH ASSESSMENT REPORT

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

I. PERSONAL DATA (TO BE COMPLETED BY PARENT OR GUARDIAN)

(Please Print Clearly)

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

Social Security Number _____
 Birthdate: ___/___/___ Sex: Male Female Race: 1 White 2 Black 3 Am. Indian 4 Asian 5 Native Hawaiian/ Other Pacific Islander 6 Other 1 Yes 2 No
mo day year Hispanic or Latino Origin

County of Residence: _____ Zip Code: _____

School your child will be attending _____

Place where your child gets regular health care: *(Check one)*
 1 Health Department 2 Emergency Room/Hospital 3 Community Health Center 4 Private Doctor/HMO 5 Other _____ No Regular Place

List health problems that might affect your child's performance in school:

II HEALTH ASSESSMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)

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: : ___/___/___ Are all immunizations complete at this time? 1 Yes 2 No
mo day year (Complete immunization history on reverse side)

Weight _____ lbs. Body Mass Index (BMI)-for age is 1 Normal (5%ile ≤85%ile) 2 Underweight (≤5%ile) 3 At-Risk of Overweight (85%ile ≤95%ile) 4 Overweight (≥95%ile)

Height: _____ ft. _____ in.
 Vision:

| | | | |
|-----|-----|-----|------|
| | R | L | Both |
| Far | 20/ | 20/ | 20/ |

Blood Pressure: _____
 Hearing:

| | | | |
|---|------|------|------|
| | 1000 | 2000 | 4000 |
| R | | | |
| L | | | |

Referred to Eye Doctor: 1 Yes 2 No With Glasses: 1 Yes 2 No
(Refer if worse than 20/40 in either eye OR 2 line difference) Purer Tone: _____ dB level (usually 20 dB)
 Permanent Hearing Loss Previously Identified: 1 Yes 2 No
 Referred to Audiologist/ENT: 1 YES 2 NO
(Referral is any failure at any frequency in either ear, or any "could not test" child.)

Comments: _____ Comments: _____

Developmental Screemomg: *(Optional)* 1 Within Normal Range 2 Needs Follow-Up Hematocrit: _____% 1 Within Normal Range 2 Needs Follow-Up
 OR Hemoglobin: _____ gm/dl

- For those illnesses or developmental problems checked above, please provide additional information on the reverse side.*
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> 1 Asthma | <input type="checkbox"/> 7 Convulsions/Seizure | <input type="checkbox"/> 13 Ear Infections | <input type="checkbox"/> 19 Skin Problems |
| <input type="checkbox"/> 2 Bleeding | <input type="checkbox"/> 8 Cystic Fibrosis | <input type="checkbox"/> 14 Heart Problems | <input type="checkbox"/> 20 Speech Problems |
| <input type="checkbox"/> 3 Bone/Muscle Problems | <input type="checkbox"/> 9 Cerebral Palsy | <input type="checkbox"/> 15 Hearing Problems | <input type="checkbox"/> 21 Stomach Aches |
| <input type="checkbox"/> 4 Bowel Problems | <input type="checkbox"/> 10 Dental Problems | <input type="checkbox"/> 16 Meningitis | <input type="checkbox"/> 22 Urinary/Bladder |
| <input type="checkbox"/> 5 Cancer/Leukemia | <input type="checkbox"/> 11 Diabetes | <input type="checkbox"/> 17 Sickle Cell Anemia | <input type="checkbox"/> 23 Other _____ |
| <input type="checkbox"/> 6 Attention/Learning | <input type="checkbox"/> 12 Emotional/Behavioral | <input type="checkbox"/> 18 Vision Problems | <input type="checkbox"/> 24 NONE |

For those illnesses or developmental problems checked above, pleased provide additional information on the reverse side.

III. IMMUNIZATION RECORD (TO BE COMPLETED ONLY BY HEALTH CARE PROVIDER)

| Enter date of EACH dose – Mo/Day/Year | | | | | |
|---|----|----|--|----|----|
| VACCINE | #1 | #2 | #3 | #4 | #5 |
| DTaP,DTP,DT | | | | | |
| Polio | | | | | |
| Hib | | | | | |
| Hepatitis B | | | | | |
| MMR | | | STATE LAW REQUIRES THE FOLLOWING MINIMUM DOSES: 5 DTaP, DTP, or DT doses (If 4 th dose is after 4 th birthday, 5 th dose is not required; DT requires medical exemption) 4 POLIO VACCINE doses (If 3 rd dose is after 4 th birthday, 4 th dose is not required) 1-4 Hib doses (Series complete if at least 1 dose given on/after 15 months and before 5 years of age; not required after age 5) 3 Hep B Doses (Children born on or after July 1, 1994 are required to have 3 doses) 2 Measles doses (at least 30 days apart; 1 st dose on/after 12 months of age) 1 Mumps dose (on/after 12 months of age) 1 Rubella dose (on/after 12 months of age) 1 Varicella dose (Children born on or after April 1, 2001 without documented history of disease) | | |
| Measles | | | | | |
| Mumps | | | | | |
| Rubella | | | | | |
| Varicella | | | | | |
| Exemptions from N.C. State Immunization Law Require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law. Consult your local health department. <input type="checkbox"/> Medical <input type="checkbox"/> Religious Exemption | | | | | |

IV. HEALTH ASSESMENT

Please provide additional information about illnesses or developmental problems checked on the reverse side. Also, provide information about any other important health conditions.

In your opinion, will any of the above illnesses or conditions affect the child's performance in school? If so, specify:

What specialized care is the child receiving related to these problems? _____

List any allergies that the child has (e.g., food, insect stings, medicine, etc.): _____

What type of allergic reaction occurs? _____

Does this child take medication on a regular basis? Yes No If yes, list medication, dose, and possible side effects.

Does this medication need to be given at school? Yes No If yes, list frequency and duration: _____

Does this child need a special diet? Yes No If yes, specify modifications: _____

Please list any additional medical care that is indicated for this child at this time: _____

Signature of Health Care Provider _____ Date: _____

Address: _____ Phone No.: _____