PPS-2K Rev. 1/03
This Form Should be Printed on Blue Paper

# PRE-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:__ __/__ __/__ __ *mo day year* Sex: ☐ Male ☐ Female

Race: ☐ 1 White ☐ 2 Black ☐ 3 Am. Indian ☐ 4 Asian ☐ 5 Native Hawaiian/ Other Pacific Islander ☐ 6 Other

Hispanic or Latino Origin ☐ 1 Yes ☐ 2 No

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: :__ __/__ __/__ __ *mo day year*

Are all immunizations complete at this time? ☐ 1 Yes ☐ 2 No *(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.

Blood Pressure:_____

Vision:

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

Hearing:

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

(*Referral is any failure at any frequency in either ear, or any "could not test" child.*)

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

Comments:_____ Comments:_____

Developmental Screemomg: (*Optional)* ☐ 1 Within Normal Range ☐ 2 Needs Follow-Up
Test(s) used _____

Hematocrit:_____% OR Hemoglobin:_____gm/dl

☐ 1 Within Normal Range ☐ 2 Needs Follow-Up:

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

☐ 1 Asthma
☐ 2 Bleeding
☐ 3 Bone/Muscle Problems
☐ 4 Bowel Problems
☐ 5 Cancer/Leukemia
☐ 6 Attention/Learning
☐ 7 Convulsions/Seizure
☐ 8 Cystic Fibrosis
☐ 9 Cerebral Palsy
☐ 10 Dental Problems
☐ 11 Diabetes
☐ 12 Emotional/Behavioral
☐ 13 Ear Infections
☐ 14 Heart Problems
☐ 15 Hearing Problems
☐ 16 Meningitis
☐ 17 Sickle Cell Anemia
☐ 18 Vision Problems
☐ 19 Skin Problems
☐ 20 Speech Problems
☐ 21 Stomach Aches
☐ 22 Urinary/Bladder
☐ 23 Other _____
☐ 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 POVIDER)**

Enter date of EACH dose – Mo/Day/Year

| **VACCINE** | #1 | #2 | #3 | #4 | #5 |
|---|---|---|---|---|---|
| DTaP,DTP,DT | | | | | |
| Polio | | | | | |
| Hib | | | | | |
| Hepatitis B | | | | | |
| MMR | | | | | |
| 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.

☐ Medical ☐ Religious Exemption

**STATE LAW REQUIRES THE FOLLOWING MINIMUM DOSES:**

5 DTaP, DTP, or DT doses (If 4th dose is after 4th birthday, 5th dose is not required; DT requires medical exemption)

4 POLIO VACCINE doses (If 3rd dose is after 4th birthday, 4th 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; 1st 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)

**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.:_____