

## 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	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns about your child's health, weight, development or behavior?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child been evaluated for any health, weight, developmental or behavioral concerns?
<input type="checkbox"/>	<input type="checkbox"/>	Is there any family history of health, weight, developmental or social/emotional concerns?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child had a dental exam by a dentist in the last 12 months?
<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_ / \_\_\_ / \_\_\_ 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

MM DD YYYY

Hispanic/Latino origin:  1 Yes  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.

<p><b>Date of Assessment:</b> ___ / ___ / ___</p> <p>Weight: ___ lbs. Height: ___ ft. ___ in</p> <p>Body Mass Index (BMI) - for age: _____</p> <p><input type="checkbox"/> 1 Normal (5%ile-&lt;85%ile)</p> <p><input type="checkbox"/> 2 Underweight (&lt;5%ile)</p> <p><input type="checkbox"/> 3 At-Risk (85%ile-95%ile)</p> <p><input type="checkbox"/> 4 Overweight (&gt;95%ile)</p> <p>Blood Pressure:</p> <p><input type="checkbox"/> 1 Within Normal Range</p> <p><input type="checkbox"/> 2 &gt; 90<sup>th</sup> Percentile</p> <p>_____ %ile</p> <p>_____ (raw)</p>	<p><b>Physical Examination</b></p> <table border="1"> <thead> <tr> <th></th> <th>Normal</th> <th>Abnormal</th> </tr> <tr> <th></th> <th>1</th> <th>2</th> </tr> </thead> <tbody> <tr><td>HEENT</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dental/Oral</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Lungs</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cardiac</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Abdomen</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Neurologic</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Back/Extremities</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Genital</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Skin</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		Normal	Abnormal		1	2	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Dental/Oral	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
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**Immunization Status (PROVIDE IMMUNIZATION RECORD- Form will not be accepted without record)**

Immunizations are up-to-date  1 YES  2 NO

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

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

**Screening Results**

	Within Normal Range	Concern Identified	Referred for Evaluation															
	1	2	3															
<b>Developmental</b>	Emotional/Social	<input type="checkbox"/>	<input type="checkbox"/>															
	Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>															
	Language/Communication	<input type="checkbox"/>	<input type="checkbox"/>															
	Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>															
	Gross Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>															
<b>Hearing</b>	<table border="1"> <tr> <td>Hearing</td> <td></td> <td>1000</td> <td>2000</td> <td>4000</td> </tr> <tr> <td></td> <td>R</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>L</td> <td></td> <td></td> <td></td> </tr> </table>			Hearing		1000	2000	4000		R					L			
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	R																	
	L																	
<p>Indicate Pass (P) or Refer (R) in each box. Refer is any failure at any frequency in either ear.</p> <p><input type="checkbox"/> With Hearing Aid (check if yes)</p> <p><input type="checkbox"/> Permanent Hearing Loss Previously Identified (check if yes)</p>																		
<b>Vision</b>	Screen Used: <input type="checkbox"/> 1 OAE <input type="checkbox"/> 2 Audiometry																	
	<input type="checkbox"/> 1 Pass																	
	<input type="checkbox"/> 2 Scheduled for re-screen due to middle ear fluid.																	
Date of rescreen appt: _____																		
<input type="checkbox"/> 3 Referral to Audiologist/ENT (check if yes)																		
<table border="1"> <tr> <td>Stereo: <input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Fail</td> <td>Test used:</td> </tr> <tr> <td>Far Both R L</td> <td></td> </tr> <tr> <td>20/ 20/ 20/</td> <td>Test used:</td> </tr> <tr> <td>With Glasses: <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No</td> <td></td> </tr> </table>				Stereo: <input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Fail	Test used:	Far Both R L		20/ 20/ 20/	Test used:	With Glasses: <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No								
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<input type="checkbox"/> 1 Pass <input type="checkbox"/> 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: _____																		