

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: _____

- | | | | | |
|--------------------------|-----------|--------------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Si | <input type="checkbox"/> | No | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | ¿Tiene alguna preocupación sobre la salud, peso, desarrollo o conducta de su niño? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | ¿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) |
| <input type="checkbox"/> | | <input type="checkbox"/> | | ¿Ha visto a su niño algún proveedor por alguna preocupación con su salud, peso, desarrollo o conducta? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | ¿Ha tenido su niño una evaluación dental en los últimos 12 meses? |
| <input type="checkbox"/> | | <input type="checkbox"/> | | ¿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

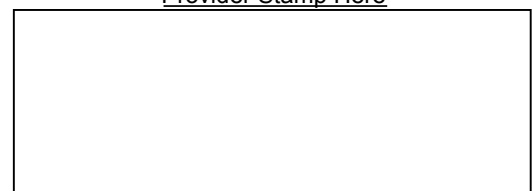
Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____



PARENT COMPLETE

Fecha de nacimiento del niño(a): ___/___/20___ (mm/dd/aaaa) Raza: 4 Indígena Americano

Sexo: 1 Masculino 2 Femenino 1 Otra Que No Sea Blanca 5 China 8 Filipina

Condado de residencia: _____ 2 Blanca 6 Japonesa 9 Otra Asiática

Código postal: _____ 3 Negra 7 Hawaiana 10 Desconocida

Origen Hispano o Latino: 1 Si 2 No

Escuela a la que asistirá su niño/niña: _____ El niño/niña tiene: 1 Medicaid 3 Sin Seguro

Lugar donde el niño/niña recibe su atención médica: 2 Seguro Privado/HMO 4 Otro: _____

1 Departamento de Salud 4 Médico Privado/Organización de Mantenimiento de la Salud (HMO)

2 Clínica del Hospital 5 Otro _____ **Nombre del Médico/Práctica:** _____

3 Centro Comunitario de Salud 6 No usa un lugar en forma regular **Nombre del Dentista:** _____

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)

- | | | |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic Conditions |
| <input type="checkbox"/> Anemia <input type="checkbox"/> At-Risk for Anemia | <input type="checkbox"/> Emotional/Behavioral | <input type="checkbox"/> Prematurity (<32 wks. EGA) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Encopresis | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Attention/Learning | <input type="checkbox"/> Enuresis (Daytime) | <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Trait |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> At-Risk for TB |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Vision Disorders |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Conditions | <input type="checkbox"/> Lead (Hx of ≥ 10 mcg/dL) <input type="checkbox"/> At-Risk <input type="checkbox"/> Test done | <input type="checkbox"/> None |
| | <input type="checkbox"/> Obese | |

Screening Results

Developmental	Screening Tool(s) Used:	Developmental Domains:	Within Normal	Concern Identified	Referred to Specialist	Comments:
	<input type="checkbox"/> 1 PEDS <input type="checkbox"/> 4 PSC <input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE		1	2	3	
		Emotional/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Language/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Gross Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hearing	Hearing	1000 Hz	2000 Hz	4000 Hz	Screening Tool Used:	Comments:
	Right				<input type="checkbox"/> 1 OAE <input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Audiometry <input type="checkbox"/> 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.	
Left				<input type="checkbox"/> 3 Referral to audiologist/ENT (check if yes) <input type="checkbox"/> 4 Child has previously diagnosed hearing loss. Screening is not necessary.		

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

Vision	Please remember that vision screening is not a substitute for a comprehensive eye examination.				Comments:
	Right	Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Far:	20/	20/	Acuity Test Used:		<input type="checkbox"/> 1 Pass (Acuity, Stereopsis, & Symptoms) <input type="checkbox"/> 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. <input type="checkbox"/> 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.
Was test performed with corrective lenses? <input type="checkbox"/> yes <input type="checkbox"/> no					

Physical Examination

Weight: _____ lbs.	Height: ___ ft. ___ in.	Normal	Abnormal
		1	2
Body Mass Index (BMI) - for age: _____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1 Underweight (< 5%ile)	HEENT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 Healthy Weight (5%ile to < 85%ile)	Dental/Oral	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 3 Overweight (85%ile to < 95%ile)	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 4 Obese (≥ 95 %ile)	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure: _____ / _____	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 1 Within Normal Range	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2 > 90 th Percentile (_____ %ile)	Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>
	Genital	<input type="checkbox"/>	<input type="checkbox"/>
	Skin	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

HEALTH CARE PROVIDER COMPLETE