New Hanover County Schools
Reach, Equip, Achieve

Early Childhood Education Program
PROGRAMA DE EDUCACIÓN TEMPRANA

1802 S 15th Street / Wilmington, NC 28401
Phone (910) 254-4390 or (910) 254-4340 / Fax (910) 254-4117

Health Assessment & Dental Verification
Evaluación de Salud y Verificación Dental

Dear Parents / *Estimados Padres*,

Thank you for your interest in the New Hanover County Schools Early Childhood Education Program. The next step in the application process is the completion of the Health Assessment and Dental Verification Forms. / *Gracias por su interés en el Programa de Educación Temprana de las Escuelas del Condado de New Hanover. El siguiente paso en el proceso de aplicación es la finalización de la Evaluación de Salud y la Forma de Verificación Dental.*

- All students entering the program are required by North Carolina state law to have a completed up-to-date Health Assessment. / *Todos los estudiantes que entran en el Programa son requeridos según la ley del estado de Carolina del Norte a completar una Evaluación de Salud actual.*
- Additional program requirements state students also need to have an up-to-date Dental Exam. / *Exigencias adicionales del programa declaran que los estudiantes también tienen que tener un Examen Dental actual.*
- Please sign the health assessment before having your provider complete the document. /*Por favor firme la hoja de evaluación de salud antes de que su médico complete el documento.*

Early Childhood Education Health Assessment Form (Yellow Form)
Hoja de Evaluación de Salud (Hoja Amarilla)

NOTE: All areas MUST be completed and signed by a physician, including:
NOTAR: Todas las áreas DEBEN ser completadas y firmadas por un médico, incluso:

- Lead / *Plomo*
- Hemoglobin / *Hemoglobina*
- Vision / *Visión*
- Hearing / *Audiencia*

Dental Verification Form (Yellow Form)
Hoja de Verificación Dental (Hoja Amarilla)

NOTE: This form must be completed and signed by a dentist or Parent/Guardian can decline services at this time by initialing and signing form.
NOTAR: Esta forma debe ser completada y firmada por un dentista o el Padre/Guardián puede rehusar servicios en este tiempo al poner sus iniciales y firmar la forma.

**** NOTE: The completed Health Assessment and Dental Verification forms MUST be submitted to 1802 S. 15th Street before the first day of school in September.**
***** NOTA: La Evaluación de Salud y la hoja de Verificación Dental deben ser entregadas a 1802 S. 15th Street antes del primer día de la escuela en septiembre.***

Like thousands of other North Carolina children, your child may be eligible for Health Check or NC Health Choice (Medicaid), free or low cost health insurance for children and teens birth through age 20. Children with one or two working parents earning $35,000 a year, or more may qualify. The program also covers children living with grandparents and other family or friends. **Contact your local Department of Social Services at (910) 798-3400 for an application**.

Como miles de otros niños de Carolina del Norte, su niño puede ser elegible para Health Check o NC Health Choice (Medicaid), un seguro médico de bajos costo o gratis para niños recién nacidos o adolescentes hasta la edad de 20 años. Los niños con un o dos padres con el ingreso total de $35,000 por año, o más pueden calificar. El programa también cubre a niños que viven con sus abuelos, otros familiares o amigos. ***Póngase en contacto con su Departamento local de Asistencia Social al (910) 798-3400 para una aplicación****.*

HEALTH CARE PROVIDERS IN NEW HANOVER COUNTY
ABASTECEDORES DE ASISTENCIA MÉDICA EN EL CONDADO DE NEW HANOVER

Abrons Family Practice: (910) 790-7840/ 1911 S. 17th St, Wilmington
Ave Maria Family Practice: (910) 799-5452/ 1230 Medical Center Dr, Wilmington
Carolina Pediatrics of Wilmington: (910) 763-2476 / 715 Medical Center Dr, Wilmington
Coastal Family Medicine: (910) 763-5522 / 2523 Delaney Ave, Wilmington
Kidz Care (910) 392-5634 / 3505 Converse Drive Suite 200, Wilmington
Knox Clinic: (910) 763-3349 / 2304 Delaney Avenue, Wilmington
MedNorth (910) 343-0270 / 925 N. 4th Street, Wilmington
NHC Health Department: (910) 798-6500 / 2029 S 17th St, Wilmington
Pelican Family Medicine: (910) 792-1001 / 5429 Wrightsville Ave, Wilmington
Seaside Pediatrics: (910) 452-1999 / 1606 Wellington Avenue, Wilmington
Southside Medical Center: (910) 763-7845 / 1925 Oleander Dr, Wilmington
Wilmington Health (Federal Point Family Practice): (910) 458-4101 / 1300-2 Bridge Barrier Rd, Carolina Beach
Wilmington Health (Mayfaire):(910) 796-7598/ 6781 Parker Farm Dr., Suite 200, Wilmington
Wilmington Health (Monkey Junction): (910) 815-4230/ 5211 S. College Road, Wilmington
Wilmington Health (Northchase): (910) 350-1787 / 4320 Henson Drive, Wilmington
Wilmington Health (Porter's Neck): (910) 686-2099 / 8108 B Market St, Wilmington
Wilmington Health (Silverstream): (910) 763-2072 / 2421 Silverstream Lane, Wilmington
Wilmington Family Physician: (910) 792-9925 / 4141 Shipyard Blvd, Wilmington

DENTAL PRACTICES IN NEW HANOVER COUNTY
PRÁCTICAS DENTALES EN EL CONDADO DE NEW HANOVER

Atlantic Dental Group: (910) 762-0958 / 1301 Physicians Drive, Wilmington
Community Dental/Brown and Associates: (910) 342-9210 / 1611 Greenfield Street, Wilmington
Coastal Carolina Pediatric Dentistry: (910) 794-2266 / 3505 Converse Dr, Wilmington
Dental Works: (910) 332-4980 / 5225 Sigmon Rd Suite 130, Wilmington
Dr. Egg Pediatric Dentistry: (910) 795-2511 / 6781 Parker Farm Drive, Wilmington
Sunshine Dentistry/Fry, Douglas, DDS: (910) 762-7736 / 2203 Delaney Avenue, Wilmington
Mobile Dental Unit: (910) 512-3113
Port City Dental: (910) 399-1127 / 4022 Oleander Drive, Wilmington
Richard S. Butler & Associates: (910) 799-9916 / 4837 Carolina Beach Rd, Wilmington
St. Mary's Health Center/Outreach: (910) 343-8736 / 412 Ann St., Wilmington
Wilmington Dental Care: (910) 790-3836 / 2520 North College Road, Wilmington
Wrightsville Dental: (910) 799-9699 / 3725 Wrightsville Ave, Wilmington

NEW HANOVER COUNTY SCHOOLS EARLY CHILDHOOD EDUCATION PROGRAM

HEALTH ASSESSMENT REPORT

Personal Data **PART 1**

PARENT COMPLETE

Child's Birthdate (mm/dd/yyyy): ____/ _____/ _____
Sex: ☐ 1 Male ☐ 2 Female

County of Residence: _____
Zip Code: _____

School your child will be attending:
_____

Place where your child gets regular health care:
☐ 1 Health Department ☐ 4 Private Provider/HMO
☐ 2 Hospital Clinic ☐ 5 Other: _____
☐ 3 Community Health Center ☐ 6 No regular place

Race: ☐ 1 Other/Non-White ☐ 5 Chinese ☐ 9 Other Asian
☐ 2 White ☐ 6 Japanese ☐ 10 Unknown
☐ 3 Black ☐ 7 Pacific Islander
☐ 4 American Indian ☐ 8 Filipino

Hispanic/Latino Origin:
☐ 1 Yes ☐ 2 No

Child has:
☐ 1 Medicaid ☐ 3 No Insurance
☐ 2 Private Insurance ☐ 4 Other: _____

Doctor/Practice Name: _____
Dentist/Practice Name: _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: _____ / _____ / _____ **Child's age at time of 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 health nurse meeting the state standards for Health Check Services.

Pertinent Illnesses, Risk or Developmental Problems: (Please check all that apply)
* Medications for serious conditions must be provided to the school with a Physician's Medication Authorization Form

☐ Allergy / Anaphylaxis*
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma*
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes"
☐ Emotional Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorder
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions*
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorder
☐ Other: _____
☐ **NONE**

Screening Results: The following sections must be completed in order to fulfill NHCS program requirements.

Lead: Hemoglobin: DATE: _____ RESULTS: _____ ☐WNL ☐NEEDS FOLLOW-UP
DATE: _____ RESULTS: _____ ☐WNL ☐NEEDS FOLLOW-UP

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 3 PSC
☐ 2 ASQ ☐ 4 ASQ-SE

Developmental Domains:	Within Normal 1	Concern s 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 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 apt. in _____weeks.
☐ 3 Referral to audiologist/ENT (check if yes)
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

	Right	Left	Stereopsis ☐Pass ☐Fail
Far:	20/	20/	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 twelve months. Screening is not necessary.

Physical Assessment

Weight: _____ lbs. Height: ____ ft. ____ in.

Body Mass Index (BMI) for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to <85%ile)
☐ 3 Overweight (85%ile to <95%ile)
☐ 4 Obese (≥ 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	☐	☐

NEW HANOVER COUNTY SCHOOLS EARLY CHILDHOOD EDUCATION PROGRAM
HEALTH ASSESSMENT REPORT

Personal Data **PART 2**

PARENT COMPLETE

Please Print Clearly – See other side for more information. Please present completed form to your child's school.

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

Birthdate(mm/dd/yyyy): ____ / ____ / _____

Address: _____City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development or behavior? **(Please explain in the comments section)**
☐	☐	Has your child been seen by a provider for any health, weight, development or behavior concern?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

_____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of the children in NC. Signature: _____ Date: _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns or Needs** ☐ **Requesting School Follow Up For:** _____

☐ **Medication:** ☐ Child takes medication for specific health conditions

List medication(s) 1. _____ 3. _____

2. _____ 4. _____

☐ **Medication must be given and/or available at school.**

Physician Authorization for Medication at School authorization form is required for medications at school.

☐ **Allergy:** Reaction: ☐ Anaphylaxis ☐ Local reaction

Allergen: ☐ Food _____ ☐ Insect:_____ ☐ Medication: _____ ☐ Other: _____

Treatment: ☐ Epinephrine Auto-injector ☐ Antihistamine ☐ Other: _____ ☐ NONE

☐ **Medication must be given and/or available at school.**

Physician Authorization for Medication at School authorization form is required for medications at school.

☐ **Special Dietary/Nutritional Needs:** _____

Medical Statement for Students with Special Nutritional Needs form must be completed by the HCP in order to meet student's dietary requirements (includes omitting foods related to allergies)

☐ **Developmental Concerns Identified:** (See comments below): Child needs referral to school support team for further evaluation.

☐ **Health-Related Recommendations to Enhance School Performance:** *For example: sitting near the front of the 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: _____

Immunizations: ☐ Copy of up-to-date Immunization Record must be provided for school.

Exemptions: NC State Immunization law requires that a statement MUST be on file in the student's permanent record. Exemptions must meet requirements of the law. Consult your local health department.

☐Religious Exemption ☐Medical Exemption:_____

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 – Please SIGN and date

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: _____

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Verification of Dental Treatment

Child's Name: _____

Parent's Name: _____

Has child ever been seen by a dentist? _____Yes ____No

Name of Dentist: _____

Date of last dental exam: _____

- ☐ Needs no treatment at this time
- ☐ Needs a routine examination in the month of _____
- ☐ Needs the following services_____
  _____
- ☐ Appointment scheduled for_____

Additional Comments:

_____

_____

Decline Dental Services for child at this time _____
(Parent/Guardian Initials)

Do you have dental insurance? ____Yes ____No

What is the name of the dental insurance? _____

Is your child now receiving: Topical Fluoride Application ____No _____Unknown _____ Yes
Fluoridated water? ____No _____Unknown _____Yes
Fluoride Supplement diet? (tablets___ liquid___) ____No ____Unknown

Signature of Dentist: _____ **Date:** _____

Provider Stamp Here

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Verificación de Examen Dental

Nombre del niño(a): _____

Nombre del Padre o Tutor Legal: _____

¿El niño(a) alguna vez ha sido visto por un dentista? _____Sí _____No

Nombre de Dentista: _____

Fecha del último examen dental: _____

- ☐ No Necesita ningún tratamiento por ahora
- ☐ Necesita un examen sistemático en el mes de _____
- ☐ Necesita los servicios siguientes_____
  _____
- ☐ Cita programada para _____

Comentarios Adicionales:

_____

_____

Rehusó Servicios Dentales para mi niño en este tiempo _____
(Iniciales de Padre/Tutor Legal)

¿Usted tienen seguro dental? ____ Sí ____No

¿Cuál es el nombre del seguro dental? _____

Su niño ahora recibe: Aplicación de Fluoruro Actual ____No _____No se ____Sí
¿**Agua con Fluoruro?** _____No _____ No se _____Sí
¿Dieta de Suplemento de fluoruro? (tabletas___ liquido___) ____No ___No se

Firma del Dentista: _____ **Fecha:** _____

Provider Stamp Here