New Hanover County Schools
Early Childhood Education Program
PreK HEALTH ASSESSMENT REPORT

Personal Data - page 1 **2020-2021**

Parent Complete

Name; _____ _____ _____
(Last) (First) (Middle)

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

Sex: ☐ 1 Male ☐ 2 Female

Race: ☐ 1 other non-White ☐ 5 Chinese ☐ 9 Other Asian
☐ 2 Caucasian ☐ 6 Japanese ☐ 10 Unknown
☐ 3 Black ☐ 7 Hawaiian
☐ 4 Native American ☐ 8 Filipino

Hispanic or Latin Origin: ☐ 1 Yes ☐ 2 No

School your child will be attending:
_____

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

Place where your child gets regular healthcare:

☐1 Health Department ☐4 Other: _____
☐2 Hospital Clinic ☐5 Private Doctor/HMO Doctor/Practice Name:_____
☐3 Community Health Center ☐6 No regular place

HEALTH CARE PROVIDER COMPLETE

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 health nurse meeting the state standards for Health Check Services. The health assessment may be no more than 12 months old at the time of program entry. .

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.

REQUIRED PRE-K SCREENING INFORMATION NEEDED:

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

Hematocrit/Hemoglobin:
DATE: _____ **RESULTS:** _____ ☐**WNL**
☐**NEEDS FOLLOW-UP**

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

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	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.

Developmental

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

Developmental Domains:	Within Normal	Concerns Identified	Referred to Specialist
Emotional/Social			
Problem Solving			
Language/Communication			
Fine Motor Skills			
Gross Motor Skills			

Physical Examination

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	☐	☐

Comments:_____

New Hanover County Schools
Early Childhood Education Program
PreK HEALTH ASSESSMENT REPORT

Personal Data – page 2 **2020-2021**

Parent Complete

Please Print Clearly

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

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

Parent or Guardian Name: _____Telephone: _____

yes	no	
☐	☐	Are you concerned with 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 comment 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 has a well-check visit or check-up in the last 12 months?

Comments: _____
_____

HEALTH CARE PROVIDER COMPLETE

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

☐ **Allergy**
☐ Food: _____
☐ Insect: _____
☐ Medicine: _____
☐ Other: _____

Type of allergic reaction:
☐ Anaphylaxis
☐ Local reaction
Response required:
☐ Epinephrine Auto-injector
☐ Other: _____

☐ Anemia ☐ At-Risk for Anemia
☐ Asthma ☐ Treated at home/no meds for school required
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Diabetes
☐ Emotional Behavioral
☐ Encopresis
☐ Enuresis

☐ Genetic Disorders
☐ Heart Conditions
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorder
☐ Other: _____
☐ NONE

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
(**Additional Form Required: *Physician's Authorization for Medication at School)***

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

☐ **Special Dietary/Nutritional Needs:** (**Additional Form Required: *Medical Statement for Students with Special Nutritional Needs)***
Guidance: _____

☐ **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**
☐ Physician's Authorization for Medication Form ☐ Diabetes Care Plan ☐ Asthma Action Plan
☐ Health Care Plan(s) List Condition _____

Comments: _____

☐ **Attach a copy of up-to-date 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

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: _____