New Hanover County Schools Early Childhood Education Program
HEALTH ASSESSMENT REPORT

Parent Complete

Child's Name: ______________________________
(LAST) (FIRST) (MIDDLE)

Birthdate (mm/dd/yyyy): ___ / ___ / _____ **School child will attend**: ____________________

Parent/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? explain:________________________________
☐	☐	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-check visit in the last 12 months?

Child has: ☐ Medicaid ☐ Private Insurance/HMO ☐ No Insurance ☐ Other: ____________________

Place where your child gets regular healthcare:
☐ Health Department ☐ Hospital Clinic ☐ Community Health Center ☐ No regular place for health care
☐ Private Doctor/HMO- Doctor/Practice Name: ______________________ ☐ Other: __________________

HEALTH CARE PROVIDER COMPLETE

DATE of Health Assessment: _______ / _______ / _________

The health assessment must be completed 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 child must have been seen by the provider within the last year, so the health assessment is ***NO MORE THAN 12 MONTHS OLD*** *at the time of the 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 guardian so it may be given to the child's regular health care provider.

REQUIRED PRESCHOOL PROGRAM SCREENING INFORMATION NEEDED:

Lead: **DATE:** ___________ **RESULTS:** ______________ ☐ **WNL** ☐ **NEEDS FOLLOW-UP**

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

HEARING Screening Tool used: ☐ OAE ☐ Audiometry
Indicate P for Pass, R for Refer.
Refer means failure at any frequency in either ear at >20dB

	1000Hz	2000Hz	4000Hz	☐ **PASS**
Right				☐ Schedule for re-screen
Left				☐ Refer to audiologist

VISION A screening is not a substitute for a comprehensive exam.
Refer if worse than 20/40 in either/both eyes, a 2 line difference between eyes, unable to test, failed stereopsis or signs of disease.

	Right	Left	Stereopsis: ☐ Pass ☐ Fail	☐ **PASS**
Far:	20/	20/	Acuity test used:	☐ Refer to eye doctor
Test performed with corrective lenses? ☐Yes ☐No				☐ Previous vision condition diagnosed

DEVELOPMENTAL Screening tool used: ☐ PEDS ☐ ASQ ☐ PSC ☐ 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: ___
☐ Underweight (<5%ile)
☐ Healthy weight (5%ile to <85%ile)
☐ Overweight (85%ile to <95%ile)
☐ Obese (≥ 95%ile)

Blood Pressure: _____/ _____
☐ Within Normal Range
☐ > 90th Percentile (_____%ile)

	Normal	Abnormal
HEENT		
Dental/Oral		
Lungs		
Cardiac		
Abdomen		
Neurological		
Back/Extremities		
Genital		
Skin		

Comments:

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↑ ↑ ↑ ↑ ↑ ↑ HEALTH CARE PROVIDER COMPLETE ↓ ↓ ↓ ↓ ↓

PERTINENT ILLNESSES, Risks of Developmental Problems: (Please check all that apply):

☐ Anemia ☐ at-risk for anemia ☐ Asthma ☐ treated at home, no meds needed at school ☐ Attention/learning ☐ Bleeding Disorder	☐ Cancer/Leukemia ☐ Cerebral Palsy ☐ Cystic Fibrosis ☐ Diabetes ☐ Emotional Behavioral ☐ Encopresis ☐ Enuresis	☐ Genetic Disorders ☐ Heart Conditions ☐ Obesity ☐ Orthopedic Conditions ☐ Prematurity (<32 weeks EGA) ☐ Seizures/Convulsions ☐ Sickle Cell Anemia ☐ Trait	☐ Speech/Language ☐ Tuberculosis ☐ at-risk for TB ☐ Vision disorder ☐ OTHER: ___________ **☐ NONE OF THESE**
☐ Allergies: **☐ NO Known Allergies**	**☐ Allergy:** ☐ Food:_______________ ☐ Insect:______________ ☐ Environment:__________ ____________________ ☐ Other:______________ ____________________	**Type of Allergic Reaction:** ☐ Immediate Anaphylaxis ☐ Delayed hypersensitivity ☐ Local reaction	**Response Required:** ☐ Emergency Action Plan in place (EAP) ☐ Epinephrine Auto-injector ☐ Other:______________ ____________________

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. ________________________ 2. ____________________________

3. ________________________ 4. ____________________________

☐ Medication must be given and/or available at school
(Please complete a NHC 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:
(Complete a NHCS Medical Statement for Students with Special Nutritional Needs for School Meals form)
Guidance: ____

☐ Health-Related Recommendations to Enhance School Performance
For example, Sitting near the front of class, special equipment needs
Please specify: ____

Comments:____

____

☐ School Health Forms attached
☐ Physician's Authorization for Medication Form ☐ Diabetes Care Plan ☐ Asthma Action Plan
☐ Special Nutritional Needs Form (food substitutions for allergies, etc)
☐ Health Care Plan(s) List Condition: _____________________________________

IMMUNIZATIONS:

☐ Please ATTACH a copy of an up-to-date immunization record.

☐ Medical Exemption ☐ Religious Exemption

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

HEALTH CARE PROFESSIONAL'S CERTIFICATION

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: ____________________________________

Provider's Signature: ______________________ Date: __________

Practice/Clinic Information:
Name: ____
Address: ____
City, State, Zip: _________________________________
Phone: ________________________ Fax: ____________

PROVIDER STAMP HERE