New Hanover County Schools Early Childhood Education Program
HEALTH ASSESSMENT REPORT

Padre / tutor completo

El nombre del niño:_____
(APELLIDO) (PRIMER NOMBRE) (SEGUNDO NOMBRE)

Fecha de nacimiento (mm/dd/yyyy): ___ /___ /_____ **A qué escuela asistirá el niño:**_____

Nombre del Padre de Familia/Guardián:_____ **Teléfono:**_____

Sí	No	
☐	☐	¿Le preocupa la salud, el peso, el desarrollo o el comportamiento de su hijo?
☐	☐	¿Alguien en su familia tiene una condición que haya afectado su salud, peso, desarrollo o ¿Conducta? explique:_____
☐	☐	¿Su hijo ha sido atendido por un proveedor por algún problema de salud, peso, desarrollo o comportamiento?
☐	☐	¿Su hijo ha tenido un examen dental por parte de un dentista en los últimos 12 meses?
☐	☐	¿Ha tenido su hijo una visita de control de bienestar en los últimos 12 meses?

El niño tiene: ☐ Medicaid ☐ Seguro privado/HMO ☐ No Seguro Médico ☐ Otro:_____

Lugar donde su hijo recibe atención médica regular:

☐ Departamento de salud ☐ Clínica hospitalaria ☐ Centro de salud comunitario
☐ No hay un lugar habitual para el cuidado de la salud ☐ Otro: _____
☐ Médico privado / HMO- Nombre del médico / consultorio:_____

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	
Right				☐ **PASS**
Left				☐ Schedule for re-screen ☐ 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			

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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:

Child's Name: _____

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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

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