PPS-2K Rev. 1/11

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: _____

Si	No	
☐	☐	¿Tiene alguna preocupación sobre la salud, peso, desarrollo o conducta de su niño?
☐	☐	¿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)
☐	☐	¿Ha visto a su niño algún proveedor por alguna preocupación con su salud, peso, desarrollo o conducta?
☐	☐	¿Ha tenido su niño una evaluación dental en los últimos 12 meses?
☐	☐	¿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's Signature: _____ Date: _____
Practice/Clinic Name: _____
Practice/Clinic Address: _____
Practice/Clinic City, State & Zip: _____
Practice Phone: _____ Fax: _____

Provider Stamp Here

-Front-

Personal Data

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PARENT COMPLETE

Fecha de nacimiento del niño(a):___/___ / 20___(mm/dd/aaaa)

Sexo: ☐ 1 Masculino ☐ 2 Femenino

Condado de residencia: _____

Código postal: _____

Escuela a la que asistirá su niño/niña: _____

Lugar donde el niño/niña recibe su atención médica:

☐ 1 Departamento de Salud
☐ 2 Clínica del Hospital
☐ 3 Centro Comunitario de Salud
☐ 4 Médico Privado/Organización de Mantenimiento de la Salud (HMO)
☐ 5 Otro _____
☐ 6 No usa un lugar en forma regular

Raza:

☐ 1 Otra Que No Sea Blanca
☐ 2 Blanca
☐ 3 Negra
☐ 4 Indígeno Americano
☐ 5 China
☐ 6 Japonesa
☐ 7 Hawaiana
☐ 8 Filipina
☐ 9 Otra Asiática
☐ 10 Desconocida

Origen Hispano o Latino: ☐ 1 Si ☐ 2 No

El niño/niña tiene:

☐ 1 Medicaid
☐ 2 Seguro Privado/HMO
☐ 3 Sin Seguro
☐ 4 Otro: _____

Nombre del Médico/Práctica: _____

Nombre del Dentista: _____

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 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)*

☐ Allergy
☐ 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 Disorders
☐ Lead (Hx of ≥10 mcg/dL) ☐ At-Risk ☐ Test done
☐ Obese
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other: _____
☐ None

Screening Results

Developmental

Screening Tool(s) Used:

☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern 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 any 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 appt. 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 12 months. Screening is not necessary.

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: _____

_____

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