

KINDERGARTEN HEALTH ASSESSMENT INSTRUCTION SHEET
FOR PARENTS

There are two sections on the form that you will need to fill out. Please print clearly.

Front: "Parent Complete."

Please write in:

1. Your child's name with last name first, then first name, then middle name or initial.
2. Your child's date of birth, starting with month, day, and year.
3. Your child's entire address, including city, state, and zipcode.
4. Your name and the phone number at which you can be reached. This may be a home number, work number, or cell phone number.
5. There are some statements that are about your child. Please answer each one by filling in the box, either "Yes" or "No":
 - Does your child have a problem that bothers you about his or her general health, how much he or she weighs, how he or she is growing, or about the way your child acts?
 - Have you taken your child to the doctor for any of these problems?
 - Does anyone in your family have any of these problems? If so, please write about it on the lines below.
 - Has your child been to the dentist in the last year?
 - Has your child been to the doctor for a checkup, not because he or she was sick, in the last year?

There is a space on the form for you to sign that will allow the school nurse to talk to your doctor about your child's health. If this is ok with you, please write your name and the date in the space. If this is not ok with you, just leave it blank.

Back: "Parent Complete"

Please write in your child's date of birth, starting with month, day, and year.

Please check the right box for your child's race. If you are not sure, check "Unknown". If your child is Hispanic or Latino, please check the box.

Please write in the county you live in, and your zip code.

Please write in the school your child will be attending.

Please check the box for where your child usually sees the doctor.

Please check the box for what kind of health insurance your child has.

Please write in the name of your child's doctor or clinic.

Kindergarten Health Assessment

Glossary of Terms

1. **Anaphylaxis:** Severe allergic reaction of the whole body that may include trouble breathing and itchy rash. It must be treated immediately or death may occur.
2. **Anemia:** Low red blood cell levels that slows oxygen flow to the body. Children with this disorder may become very tired or have low energy levels.
3. **At-Risk:** The provider will ask you some questions to see if your child may be at risk of having these problems.
4. **BMI (Body Mass Index):** A formula that relates weight to height for measuring over and under weight in children.
5. **Cardiac:** Pertaining to the heart and circulatory system.
6. **Cerebral Palsy:** Children born with this permanent disorder have trouble moving, standing, talking, listening and understanding.
7. **Cystic Fibrosis:** Children born with this permanent disorder have trouble breathing and digesting food.
8. **Diabetes:** Children who have this have trouble controlling their blood sugar. These children eat foods that are low in sugar or need medicine or shots to help control their blood sugar.
9. **EGA (Prematurity):** Baby born earlier than 8 weeks before the due date.
10. **ENT:** Ear, Nose and Throat Specialist
11. **Epinephrine auto-injector:** Automatic shot of medicine for severe allergic reactions prescribed by the doctor
12. **Encopresis:** Children with this have trouble controlling bowel movements.
13. **Enuresis:** Children with this have trouble controlling passage of their water.
14. **HEENT (Head, Eyes, Ears, Nose & Throat):** An examination of the head, eyes, ears, nose and throat done by the doctor.
15. **HMO (Health Maintenance Organization):** Type of medical provider group.
16. **Hx:** Abbreviation for "history." For example: Has your child ever had problems with high levels of lead in his/her blood?
17. **School Follow Up:** When this box is checked, the form should go to the School Nurse so he/she can follow up on any health concerns documented on the form.
18. **Sickle Cell Anemia:** Children born with this permanent disorder have blood problems that cause severe pain and trouble breathing that comes and goes.
19. **TB (Tuberculosis):** Children with this illness have trouble breathing and coughing. Children who have this condition are on medication to cure this illness.
20. **Test Done:** The provider will ask you if your child has ever been tested for high levels of lead in their blood.

Developmental Screening Tools: Tools used by the doctor to see if a child is developing normally.

- **ASQ:** Ages and Stages Questionnaire
- **ASQ-SE:** Ages and Stages Questionnaire for Social and Emotional Behavior
- **Brigance:** A developmental testing tool for doctors to use.
- **CDI:** Child Development Inventory or Communication Developmental Inventory
- **IDI:** Infant Developmental Inventory
- **PEDS:** Parent Evaluation of Developmental Status
- **PSC:** Pediatric Symptom checklist
- **OAE:** Otoacoustic Emissions Test (Sounds that are produced by healthy ears in response to acoustic stimulation.

NORTH CAROLINA KINDERGARTEN HEALTH ASSESSMENT REPORT

(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 **

Please Print Clearly - See other side for more required information

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

Birth Date: ____ / ____ / ____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you concerned about your child's health, weight, development or behavior? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child been seen by a provider for any health, weight, development or behavior concern? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anyone in your family have a condition that has affected their health, weight, development or behavior? (Please explain in the comments section) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental exam by a dentist in the last 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 children in NC. Signature: _____ Date: _____

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

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: _____

PARENT COMPLETE

HEALTH CARE PROVIDER COMPLETE

PARENT COMPLETE

Child's Birthdate: ____/____/____ (mm/dd/yyyy) Race: 1 Other Non-White 5 Chinese 9 Other Asian
 Sex: Male Female 2 White 6 Japanese 10 Unknown
 County of Residence: _____ 3 Black 7 Hawaiian
 Zip Code: _____ 4 American Indian 8 Filipino

School your child will be attending: _____ Hispanic or Latino Origin: 1 Yes 2 No

Place where your child gets regular health care: Child has:

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

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)

<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Anemia <input type="checkbox"/> At-Risk for Anemia	<input type="checkbox"/> Emotional/Behavioral	<input type="checkbox"/> Prematurity (<32 wks. EGA)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Encopresis	<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Attention/Learning	<input type="checkbox"/> Enuresis (Daytime)	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Genetic Disorders	<input type="checkbox"/> Speech/Language
<input type="checkbox"/> Cancer/Leukemia	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> At-Risk for TB
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Lead (Hx of >10 mcg/dL) <input type="checkbox"/> At-Risk <input type="checkbox"/> Test done	<input type="checkbox"/> None

Screening Results

Developmental	Screening Tool(s) Used:		Developmental Domains:			Within Normal	Concern Identified	Referred to Specialist	Comments: _____ _____ _____										
	<input type="checkbox"/> 1 PEDS <input type="checkbox"/> 4 PSC	<input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE	<input type="checkbox"/> 3 IDI/CDI <input type="checkbox"/> 6 Brigance	Emotional/Social	Problem Solving	Language/Communication	Fine Motor Skills	Gross Motor Skills		1	2	3							
Hearing	Hearing	1000 Hz	2000 Hz	4000 Hz	Screening Tool Used:					<input type="checkbox"/> 1 Pass <input type="checkbox"/> 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks. <input type="checkbox"/> 3 Referral to Audiologist/ENT (check if yes) <input type="checkbox"/> 4 Child has previously diagnosed hearing loss. Screening is not necessary.									
	Right				<input type="checkbox"/> 1 OAE														
Vision	Please remember that vision screening is not a substitute for a comprehensive eye examination.					<input type="checkbox"/> 1 Pass													
		Both	Right	Left		<input type="checkbox"/> 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 or unable to test)													
<table border="1"> <tr> <td></td> <td>Both</td> <td>Right</td> <td>Left</td> <td></td> </tr> <tr> <td>Far:</td> <td></td> <td></td> <td></td> <td>Test Used:</td> </tr> </table>						Both	Right	Left		Far:				Test Used:	<input type="checkbox"/> 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.				
	Both	Right	Left																
Far:				Test Used:															
Was test performed with corrective lenses? <input type="checkbox"/> yes <input type="checkbox"/> no																			

Physical Examination

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

Body Mass Index (BMI) - for age: _____

1 Normal (5%ile - <85%ile)
 2 Underweight (<5%ile)
 3 At-Risk (85%ile to <95%ile)
 4 Overweight (95%ile)

Blood Pressure: _____ / _____

1 Within Normal Range
 2 > 90th Percentile (_____ %ile)

	Normal	Abnormal
	1	2
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Dental/Oral	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Genital	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

HEALTH CARE PROVIDER COMPLETE