KINDERGARTEN HEALTH ASSESSMENT REPORT

(Approved by North Carolina Department of Public Instruction and Department of Environment, Health, and Natural Resources)

I. PERSONAL DATA (TO BE COMPLETED BY PARENT OR GUARDIAN)

(Please Print Clearly)

Child's Name ______________________________ ______________________________ ____________________

Last First Middle

Birthdate: __ __ / __ __ / __ __ (mo. day year) Sex: 1 Male 2 Female Race: 1 White 2 Black 3 Am. Indian 4 Other Hispanic: 1 Yes 2 No

County of Residence: ____________________________ Zip Code: __ __ __ __ __

School your child will be attending ____

Place where your child gets regular health care: *(Check one)*

1 Health Department
2 Emergency Room/Hospital
3 Community Health Center
4 Private Doctor/HMO
5 Other ________________
6 No Regular Place

List health problems that might affect your child's performance in school: ____________________________________

____

____

II. HEALTH ASSESSMENT (*TO BE COMPLETED BY HEALTH CARE PROVIDER*)

The health assessment must be conducted by a physician licensed to practice medicine, a physicians' 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.

Date of Assessment: __ __ / __ __ / __ __ (mo. day year)

Are all immunizations complete at this time? 1 Yes 2 No
(Complete immunization history on reverse side)

Weight: ______ lbs. Weight relative to height is: 1 Normal 2 Underweight 3 Overweight

Height: ______ ft. ______ in. Blood Pressure: _______/________

Vision:

	R	L	Both
Far	20/	20/	20/

Hearing:

	500	1000	2000	4000
R	dB	dB	dB	dB
L	dB	dB	dB	dB

With Glasses: 1 Yes 2 No

Needs Follow-up: 1 Yes 2 No

Pure Tone: _____ dB (usually 20dB)

With Hearing Aid: 1 Yes 2 No

Needs Follow-up: 1 Yes 2 No

Development: 1 Within Normal Range 2 Needs Follow-up

Test(s) used (optional) ____________________________

Hematocrit: _______ %
OR
Hemoglobin: _______ gm/dl

1 Within Normal Range
2 Needs Follow-up

Illnesses or Developmental Problems *(Please check any of the following that the child has)*:

1 Asthma
2 Bleeding Problems
3 Bone/Muscle Problems
4 Bowel Problems
5 Cancer/Leukemia
6 Attention/Learning
7 Convulsions/Seizures
8 Cystic Fybrosis
9 Cerebral Palsy
10 Dental Problems
11 Diabetes
12 Emotional/Behavioral
13 Ear Infections
14 Heart Problems
15 Hearing Problems
16 Meningitis
17 Sickle Cell Anemia
18 Vision Problems
19 Skin Problems
20 Speech Problems
21 Stomach Aches
22 Urinary/Bladder
23 Other ___________
24 NONE

For those illnesses or developmental problems checked above, please provide additional information on the reverse side.

III. IMMUNIZATION RECORD (*TO BE COMPLETED ONLY BY HEALTH CARE PROVIDER*)

Enter date of EACH dose – Mo/Day/Year

VACCINE	#1	#2	#3	#4	#5
DTP,DTaP,DT					
Polio					
Hib					
Hepatitis B					
MMR					
Measles					
Mumps					
Rubella					
Varicella					

Exemptions from N.C. State Immunization Law require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law. Consult your local health department.

Medical Religious Exemption

STATE LAW REQUIRES THE FOLLOWING MINIMUM DOSES:

5 DTP,DTaP,DT doses (if 4th dose is after 4th birthday, 5th dose is not required.)

4 POLIO VACCINE doses (if 3rd dose is after 4th birthday, 4th dose is not required.)

1 Hib dose – At least 1 Hib on/after 1st birthday and before 5 years of age. (Not required after age 5)

2 MMR doses (1st dose on/after 1st birthday)

3 Hepatitis B 1 Varicella (chickpox)

IV. FURTHER HEALTH INFORMATION (*TO BE COMPLETED BY HEALTH CARE PROVIDER*)

Please provide additional information about illnesses or developmental problems checked on the reverse side. Also, provide information about any other important health conditions.

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____

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In your opinion, will any of the above illnesses or conditions affect the child's performance in school? If so, specify:

____

____

What specialized care is the child receiving related to these problems? ______________________________

____

____

List any allergies that the child has (e.g., food, insect stings, medicine, etc.): ______________________________

What type of allergic reaction occurs? ______________________________

Does this child take medication on a regular basis? Yes No If yes, list medication, dose, and possible side effects.

____

Does this medication need to be given at school? Yes No If yes, list frequency and duration: ______________________________

____

Does this child need a special diet? Yes No If yes, specify modifications: ______________________________

____

Please list any additional medical care that is indicated for this child at this time: ______________________________

____

Signature of Health Care Provider ______________________________ Date: ______________________________

Address: ______________________________ Phone No.: ______________________________