NEW HANOVER COUNTY SCHOOLS EARLY CHILDHOOD EDUCATION PROGRAM
HEALTH ASSESSMENT REPORT

Personal Data — PART 1

PARENT COMPLETE

Child's Birthdate (mm/dd/yyyy): ____/ _____/ _____
Sex: ☐ 1 Male ☐ 2 Female

County of Residence: _____
Zip Code: _____

School your child will be attending:
_____

Place where your child gets regular health care:
☐ 1 Health Department ☐ 4 Private Provider/HMO
☐ 2 Hospital Clinic ☐ 5 Other: _____
☐ 3 Community Health Center ☐ 6 No regular place

Race: ☐ 1 Other/Non-White ☐ 5 Chinese ☐ 9 Other Asian
☐ 2 White ☐ 6 Japanese ☐ 10 Unknown
☐ 3 Black ☐ 7 Pacific Islander
☐ 4 American Indian ☐ 8 Filipino

Hispanic/Latino Origin:
☐ 1 Yes ☐ 2 No

Child has:
☐ 1 Medicaid ☐ 3 No Insurance
☐ 2 Private Insurance ☐ 4 Other: _____

Doctor/Practice Name: _____
Dentist/Practice Name: _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: _____ / _____ / _____ **Child's age at time of 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 health nurse meeting the state standards for Health Check Services.

Pertinent Illnesses, Risk or Developmental Problems: (Please check all that apply)

* Medications for serious conditions must be provided to the school with a Physician's Medication Authorization Form

☐ Allergy / Anaphylaxis*
☐ 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 Disorder
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions*
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorder
☐ Other: _____
☐ **NONE**

Screening Results: The following sections must be completed in order to fulfill NHCS program requirements.

Lead:
Hemoglobin:
DATE: _____ RESULTS: _____ ☐ WNL ☐ NEEDS FOLLOW-UP
DATE: _____ RESULTS: _____ ☐ WNL ☐ NEEDS FOLLOW-UP

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 3 PSC
☐ 2 ASQ ☐ 4 ASQ-SE

Developmental Domains:	Within Normal 1	Concern s 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 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 apt. in _____ weeks.
☐ 3 Referral to audiologist/ENT (check if yes)
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

	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 twelve months. Screening is not necessary.

Physical Assessment

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	☐	☐

NEW HANOVER COUNTY SCHOOLS EARLY CHILDHOOD EDUCATION PROGRAM
HEALTH ASSESSMENT REPORT

Personal Data **PART 2**

PARENT COMPLETE

Please Print Clearly – See other side for more information. Please present completed form to your child's school.

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

Birthdate(mm/dd/yyyy): ____ / ____ / _____

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

Parent/Guardian Name: _____ Phone: _____

Yes	No	
☐	☐	Are you concerned about 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? **(Please explain in the comments section)**
☐	☐	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-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 the children in NC. Signature: _____ Date: _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns or Needs** ☐ **Requesting School Follow Up For:** _____

☐ **Medication:** ☐ Child takes medication for specific health conditions
List medication(s) 1. _____ 3. _____
2. _____ 4. _____

☐ **Medication must be given and/or available at school.**
Physician Authorization for Medication at School authorization form is required for medications at school.

☐ **Allergy:** Reaction: ☐ Anaphylaxis ☐ Local reaction
Allergen: ☐ Food _____ ☐ Insect: _____ ☐ Medication: _____ ☐ Other: _____
Treatment: ☐ Epinephrine Auto-injector ☐ Antihistamine ☐ Other: _____ ☐ NONE

☐ **Medication must be given and/or available at school.**
Physician Authorization for Medication at School authorization form is required for medications at school.

☐ **Special Dietary/Nutritional Needs:** _____
Medical Statement for Students with Special Nutritional Needs form must be completed by the HCP in order to meet student's dietary requirements (includes omitting foods related to allergies)

☐ **Developmental Concerns Identified:** (See comments below): Child needs referral to school support team for further evaluation.

☐ **Health-Related Recommendations to Enhance School Performance:** *For example: sitting near the front of the 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: _____

Immunizations: ☐ **Copy of up-to-date Immunization Record must be provided for school.**

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

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 – Please SIGN and date

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: _____