JOHNSTON COUNTY
PRESCHOOL HEALTH ASSESSMENT REPORT

Parent Complete

1. PERSONAL DATA

Name of child :_____
(Last) (First) (Middle)

Birthdate:_____/_____/_____ **Sex:** ____Male ____Female **County of Residence:**_____

Race: ____White ____Black ____American Indian ____Asian ____Other:_____

Hispanic or Latino Origin: ____Yes ____No

Place where you child gets regular health care:

____Health Department ____Emergency Room/Hospital ____Private Doctor/HMO
____Community Health Center ____No Regular Place ____Other _____

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 weight, development or behavior? (Please explain in comment section)
___	___	Has your child been seen by a doctor for any health, weight, development or behavior concern?
___	___	Has your child has a well-child visit or check-up in the last 12 months?
___	___	Has your child ever been to a dentist?
___	___	Do you have a family dentist?

Comments:_____

_____

Health Care Provider

ATTN: HEALTH CARE PROVIDER-PLEASE READ

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners, a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT. The health care provider must fill out the remainder of this form in its *entirety*, as this information is mandated by the General Assembly for all NC Pre-K program participants. The health care provider is responsible for making appropriate referrals as indicated by the health assessments.

2. IMMUNIZATION RECORD-ATTACH A COPY OF THE IMMUNIZATION RECORD

Are all immunizations complete at this time? ____Yes ____No

Immunization Record Attached: ____Yes ____No

G.S.>130A-155(b) requires all child care facilities to have this information on file. Exceptions from NC State Immunization Law require that a statement must be on file at school in the student's record. Exemptions must meet requirements of this law.

Exempt from Immunizations: (Attach appropriate form) ____Religious ____Medical

3. HEALTH HISTORY, PERTINENT ILLNESSES, RISKS OR DEVELOPMENTAL PROBLEMS: *CHECK ALL THAT APPLY*

___Allergy	___ Diabetes	___Orthopedic Cond.
___Anemia	___Emotional	___Prematurity <32
___Asthma	___Encopresis	___Seizures
___Attention/Learning	___Enuresis	___Sickle Cell Anemia ___Trait
___Behavioral	___Genetic Disorder	___Speech/Language
___Bleeding Disorder	___Heart Condition	___TB ___at risk
___Cancer/Leukemia	___Hearing Disorder	___Vision Disorder
___Cerebral Palsy	___Kidney Disorder	___Lead (Hx>10 mcg/dL)
___Cystic Fibrosis	___Obesity	___At Risk ___Test Done

Health Care Provider

Health Care Provider

4. HEALTH ASSESSMENT: DATE OF ASSESSMENT_____/_____/_____ WEIGHT:_____ HEIGHT:_____

Developmental

Screening Tool(s) Used:	Developmental Domains:	Within Normal	Concern Identified	Referred to Specialist
___PEDS ___PSC	Social/Emotional	_____	_____	_____
___ASQ ___ASQ-SE	Problem Solving	_____	_____	_____
	Language/Communication	_____	_____	_____
	Fine Motor Skills	_____	_____	_____
	Gross Motor Skills	_____	_____	_____

Hearing

Screening Tool(s) Used:

___OAE ___AUDIOMETRY

STATUS:

___PASS ___Re-screen due to fluid

___Referral to ENT ___Previous Hearing Loss Diagnosis

Indicate Pass (P) or Refer (R) in each box.

Refer means any failure at any frequency in either ear at >20dB.

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Vision

STATUS:

___Pass (Acuity, Stereopsis, & Symptoms)

___Referral to eye doctor:

___Previous vision condition diagnosis

Vision	Right	Left	Stereopsis: ___Pass ___Fail
Far	20/____	20/____	Acuity Test Used: _____
Was test performed with corrective lenses? ___Yes ___No			

Dental

STATUS:

___No Obvious Problems ___Possible problem areas, check at next dental visit ___Dental attention is needed as soon as possible

Regular dental visits are recommended to maintain your child's dental health. Ask your dentist about sealants to prevent cavities.

5. RECOMMENDATIONS TO SCHOOL PERSONNEL BASED ON HEALTH ASSESSMENT

___No Recommendations, Concerns or Needs ___Requesting School Follow Up

___Developmental Concerns Identified ___Child needs referral to school support team for further evaluation

___Referral has been made for further evaluation. (please attach a copy of the referral)

___Health related recommendations to enhance school performance:_____

Medication: ___Must be made available at school Child takes the following medication(s): 1._____

2._____ 3._____ 4._____

Allergy: ____Food ____Insect ____Medicine ____Other:_____

Type of reaction: ____Anaphylaxis ____Local reaction

Response required: ____Epinephrine Auto-injector ____Other:_____ ____ None

School Forms Attached: ___ School Medication Authorization Form ___ Diabetes Care Plan ___ Asthma Action Plan

___ Health Care Plan: _____

___Child requires a special diet: _____

___At least one of the above illnesses or conditions will restrict the child's participation in any preschool activity or will have the potential to interfere with the child's development and learning.

Comments:_____

_____

_____

Provider Stamp Here

Provider's Name: _____ Date:_____

Provider's Signature: _____

Practice/Clinic Name:_____

Practice/Clinic Address::_____

Practice/Clinic Phone:_____ Fax:_____

Revised 1/24/2014