PPS-2K Rev. 1/03
This Form Should be Printed on Blue Paper

KINDERGARTEN HEALTH ASSESSMENT REPORT

(Approved by North Carolina Department of Public Health Instruction and Department of Health and Human Services)

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

(***Please Print Clearly***)

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

Social Security Number__ __ __-__ __-__ __ __ __

Birthdate:__ __/__ __/__ __ *mo day year* Sex: ☐ Male ☐ Female

Race: ☐ 1 White ☐ 2 Black ☐ 3 Am. Indian ☐ 4 Asian ☐ 5 Native Hawaiian/ Other Pacific Islander ☐ 6 Other

Hispanic or Latino Origin ☐ 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 _____ ☐ 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 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.

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. Body Mass Index (BMI)-for age is ☐ 1 Normal (5%ile ≤85%ile) ☐ 2 Underweight (≤5%ile) ☐ 3 At-Risk of Overweight (85%)ile-≤95%ile ☐ 4 Overweight (≥95%ile)

Height:_____ft. _____in.

Blood Pressure:_____

Vision:

	R	L	Both
Far	20/	20/	20/

Hearing:

	1000	2000	4000
R			
L			

(*Referral is any failure at any frequency in either ear, or any "could not test" child.*)

Referred to Eye Doctor: ☐ 1 Yes ☐ 2 No
With Glasses: ☐ 1 Yes ☐ 2 No
(*Refer if worse than 20/40 in either eye OR 2 line difference*)

Purer Tone:_____dB level (usually 20 dB)
Permanent Hearing Loss Previously Identified: ☐ 1 Yes ☐ 2 No
Referred to Audiologist/ENT: ☐ 1 YES ☐ 2 NO

Comments:_____ Comments:_____

Developmental Screemomg: (*Optional)* ☐ 1 Within Normal Range ☐ 2 Needs Follow-Up
Test(s) used _____

Hematocrit:_____% OR Hemoglobin:_____gm/dl

☐ 1 Within Normal Range ☐ 2 Needs Follow-Up:

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

☐ 1 Asthma
☐ 2 Bleeding
☐ 3 Bone/Muscle Problems
☐ 4 Bowel Problems
☐ 5 Cancer/Leukemia
☐ 6 Attention/Learning
☐ 7 Convulsions/Seizure
☐ 8 Cystic Fibrosis
☐ 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, pleased provide additional information on the reverse side.

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

Enter date of EACH dose – Mo/Day/Year

VACCINE	#1	#2	#3	#4	#5
DTaP,DTP,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 DTaP, DTP, or DT doses (If 4th dose is after 4th birthday, 5th dose is not required; DT requires medical exemption)

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

1-4 Hib doses (Series complete if at least 1 dose given on/ after 15 months and before 5 years of age; not required after age 5)

3 Hep B Doses (Children born on or after July 1, 1994 are required to have 3 doses)

2 Measles doses (at least 30 days apart; 1st dose on/after 12 months of age

1 Mumps dose (on/after 12 months of age)

1 Rubella dose (on/after 12 months of age)

1 Varicella dose (Children born on or after April 1, 2001 without documented history of disease)

IV. HEALTH ASSESMENT

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

_____

_____

_____

_____

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.:_____