PPS-2K Rev. 1/11

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 **

PARENT COMPLETE

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

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

Birth Date: ____ / ____ / 20 ____ (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 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**

☐ **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 - Attach a copy of the immunization record.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: LEAMOR BUENASEDA, MD, FAAP
Provider's Signature: _____ Date: _____
Practice/Clinic Name: KIDS FIRST PEDIATRICS OF RAEFORD
Practice/Clinic Address: 4005 FAYETTEVILLE ROAD
Practice/Clinic City, State & Zip: RAEFORD, NC, 28376
Practice Phone: (910) 848-5437 Fax: (910) 848-5439

Provider Stamp Here

Leamor Buenaseda, MD,FAAP
KIDS FIRST PEDIATRICS OF RAEFORD
4005 Fayetteville Road, Raeford, NC, 28376
Phone: 910-848-KIDS (5437)
Fax 910-848-5439

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Personal Data

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PARENT COMPLETE

Child's Birthdate: ____ /____ 20 ____ (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
☐ 2 Hospital Clinic
☐ 3 Community Health Center
☐ 4 Private Doctor/HMO
☐ 5 Other _____
☐ 6 No regular place

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

Hispanic or Latino Origin: ☐ 1 Yes ☐ 2 No

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

Doctor/Practice Name: _____

Dentist Name: _____

HEALTH CARE PROVIDER COMPLETE

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)*

☐ Allergy
☐ 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 Disorders
☐ Lead (Hx of ≥10 mcg/dL) ☐ At-Risk ☐ Test done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other: _____
☐ None

Screening Results

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE

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

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	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 12 months. Screening is not necessary.

Physical Examination

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	☐	☐

Comments: _____ _____

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