

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

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

Birth Date: ____ / ____ / ____ (mm/dd/yyyy)

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

Parent/Guardian Name: _____ Phone: _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you concerned about your child's health, weight, development or behavior? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child been seen by a provider for any health, weight, development or behavior concern? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anyone in your family have a condition that has affected their health, weight, development or behavior? (Please explain in the comments section) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental exam by a dentist in the last 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

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: _____



