

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 **

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: _____

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: _____

Provider Stamp Here

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____

PARENT COMPLETE

HEALTH CARE PROVIDER COMPLETE