PPS-2K Rev. 9/96

KINDERGARTEN HEALTH ASSESSMENT REPORT

(Approved by North Carolina Department of Public Instruction and Department of Environment, Health, and Natural Resources)

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

(Please Print Clearly)

Child's Name ______________________ ______________________ ______________________
Last *First* *Middle*

Birthdate: __ __/__ __/__ __ *mo. day year*

Sex: ☐ 1 Male ☐ 2 Female

Race: ☐ 1 White ☐ 2 Black ☐ 3 Am. Indian ☐ 4 Other

Hispanic: ☐ 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 ______________
☐ 6 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. Weight relative to height is: ☐ 1 Normal ☐ 2 Underweight ☐ 3 Overweight

Height: _____ ft. _____ in. **Blood Pressure:** _______/_______

Vision:

	R	L	Both
Far	20/	20/	20/

With Glasses: ☐ 1 Yes ☐ 2 No

Needs Follow-Up: ☐ 1 Yes ☐ 2 No

Hearing:

	500	1000	2000	4000
R				
L				

Pure Tone: ______ dB level (usually 20 dB)
With Hearing Aid: ☐ 1 Yes ☐ 2 No

Needs Follow-Up: ☐ 1 Yes ☐ 2 No

Development: ☐ 1 Within Normal Range ☐ 2 Needs Follow-up
Test(s) used (optional) ______________________

Hematocrit: _______ %
OR
Hemoglobin: _______ gm/dl

☐ 1 Within Normal Range
☐ 2 Needs Follow-up

Illnesses or Developmental Problems *(Please check any of the following that the child has)*:

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