NORTH CAROLINA PRE-K HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school / child care center attended by the student named herein and is confidential and not a public record.

PARENT - COMPLETE THIS SECTION

Child's Name: _____ _____ _____ **Gender:** ❑ M ❑ F
(Last) (First) (Middle)

Birthdate (M/D/YYYY): _____ / _____ / _____ **School Name: Johnston County NC Pre-K Program**

Hispanic or Latino Origin: ❑ Yes ❑ No

Race: ❑ White ❑ Black ❑ Asian ❑ Hawaiian/Pacific Islander ❑ Native American/Alaskan ❑ Unknown ❑ Other: _____

Home Address:_____ City: _____ State: _____ County: _____

Parent / Guardian Name: _____

Telephone Number(s): Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER - COMPLETE NEXT TWO (2) SECTIONS

NC Pre-K Required Screenings

Vision screening information:
- ❑ Pass ❑ Fail ❑ Uncooperative
- ❑ Referred: _____
- ❑ Rescreen in __ weeks/months

Concerns related to student's vision:

Hearing screening information:
- ❑ Pass ❑ Fail ❑ Uncooperative
- ❑ Referred: _____
- ❑ Rescreen in __ weeks/months

Concerns related to student's hearing:

Dental Screening Information:
- ❑ No Obvious Problems
- ❑ Possible problem areas, check at next dental visit
- ❑ Dental attention is needed as soon as possible
  - ❑ Referred to dentist
  - ❑ Already under dentist's care

Developmental Screening: Date of Screening:_____

Screening Tool Used: ❑ ASQ ❑ PEDS ❑ PEDS-DM ❑ SWYC ❑ OTHER: _____

- ❑ Within Normal Limits
- ❑ Concerns Identified (no referral)
- ❑ Referral made to : _____
  Date: _____

Areas of concern:
- ❑ Speech ❑ Gross Motor ❑ Fine Motor
- ❑ Overall Development ❑ Social / Emotional
- ❑ Other: _____

Please attach screening and referral (if any)

NORTH CAROLINA
NC Pre-K
Prekindergarten Program

Medical History and Recommendations

Medications prescribed for student:

Students allergies - type and response required:

Special diet instructions:

Special health care needs of child:

Health-related recommendations to enhance the student's school performance:

Recommendations, concerns, or needs related to student's health / development that require school follow-up:

Additional health care provider comments:

Please attach all applicable school health forms:

- ❑ Immunization record
- ❑ School medication authorization form
- ❑ Diabetes care plan
- ❑ Asthma action plan
- ❑ Health care plans for other conditions

Health Care Professional's Certification

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screenings for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Date of health assessment: _____ Well child check for ❑ 3 yr old ❑ 4 yr old ❑ 5 yr old Next apt: _____

Name: _____ Title: _____

Signature: _____ Date (m/d/yyyy): _____

Practice/Clinic Name and address:			Provider Stamp Here:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax: