ATTENTION PHYSICIANS AND STAFF COMPLETING THE NC HEALTH ASSESSMENT TRANSMITTAL FORM

This child is an applicant for the NC Pre-K Program.

Our program is subject to all childcare licensing rules and regulations.

In order to comply with DCDEE Licensing, each child enrolled in the NC Pre-K program is ***required*** to have a full ***vision, hearing***, and ***dental screening*** before entering the classroom.

We ask that you complete these screenings during the well-child check. If the child is uncooperative or cannot complete the screenings for some reason, make note with brief details in the appropriate sections of the form.

If the form is being completed for a ***3-year-old exam***, please note this on the form as well as when the next well child check is scheduled.

We ask that you also provide a ***copy of any developmental screenings completed*** if they resulted in a concern identified or a referral. A ***copy of the referral*** is also requested for follow-up if necessary.

We thank you for your help and cooperation in completing this form.

Deana K. Murphy
Director, Pre-Kindergarten Services
Gaston County Schools

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 HELP OF JOHNSTON COUNTY

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

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: