Kindergarten Health Assessment (KHA) Report with Data Summarization Sheet

KHA developed by the NC Department of Instruction and the NC Department of Environment, Health, and Natural Resources

Evaluation Tool
Smart Start Evaluation Team

FPG Child Development Institute
UNC-Chapel Hill

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 ☐ 3 Am. Indian ☐ 2 Black ☐ 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 Statue 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 Development 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 development problems checked above, please provide additional information on the reverse side.

III. IMMUNIZATION HISTORY *(TO BE COMPLETED BY HEALTH CARE PROVIDER)*

Enter date of EACH dose - Mo/Day/Year

VACCINE	#1	#2	#3	#4	#5
DTP, DTaP, DT					
Polio					
Hib					
Hepatitis B					
MMR					
Measles					
Mumps					
Rubella					
Varicella					

Exemptions from N.C. State Immunization Law require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law. Consult your local health department.

☐ Medical ☐ Religious Exemption

STATE LAW REQUIRES THE FOLLOWING MINIMUM DOSES:

5 DTP, DTaP, DT doses (if 4th dose is after 4th birthday, 5th dose is not required.)

4 POLIO VACCINE doses (if 3rd dose is after 4th birthday, 4th dose is not required.)

1 Hib dose - At least 1 Hib on/after 1st birthday and before 5 years of age. (Not required after age 5)

2 MMR doses (1st dose on/after 1st birthday)

IV. FURTHER HEALTH INFORMATION *(TO BE COMPLETED BY HEALTH CARE PROVIDER)*

Please provide additional information about illnesses or developmental problems checked on the reverse side. Also, provide information about any other important health conditions.

____

____

____

____

____

In your opinion, will any of the above illnesses or conditions affect the child's performance in school? If so, specify:

____

____

What specialized care is the child receiving related to these problems? ______________________

____

____

List any allergies that the child has (e.g., food, insect stings, medicine, etc.): ______________________

What type of allergic reaction occurs? ______________________

Does this child take medication on a regular basis? ☐ Yes ☐ No If yes, list medication, dose, and possible side effects.

____

Does this medication need to be given at school? ☐ Yes ☐ No If yes, list frequency and duration: ______________

____

Does this child need a special diet? ☐ Yes ☐ No If yes, specify modifications: ______________________

____

Please list any additional medical care that is indicated for this child at this time: ______________________

____

Signature of Health Care Provider ______________________ Date: ______________

Address: ______________________________ Phone No.: ______________

Kindergarten Health Assessment Data Sheet

___ ___ / _____/___ ___ ___/___ ___ ___
county setting school code indiv. ID

Evaluator's Initials: ___ ___ ___

Date: ___ ___ / ___ ___ / ___ ___

I. Personal Data

1. Birthdate: __ __/__ __/__ __ ❐ Missing
2. Sex: ❐ Male ❐ Female ❐ Missing

II. Health and Behavioral History

3. Where does your child get regular health care?

a. ❐ Health Dept.
b. ❐ Emergency Room/Hospital
c. ❐ Community Health Center
d. ❐ Private Provider
e. ❐ Other
f. ❐ Missing

4. Has your child ever had an evaluation at a developmental evaluation center, by a psychologist or other health specialist? ❐ Yes ❐ No ❐ Missing

III. Immunizations

Vaccine	#1	#2	#3	#4	#5
5. DPT				a. _ _/_ _/_ _	b. _ _/_ _/_ _
6. DT				a. _ _/_ _/_ _	b. _ _/_ _/_ _
7. OPV			a. _ _/_ _/_ _	b. _ _/_ _/_ _	
8. MMR	a. _ _/_ _/_ _	b. _ _/_ _/_ _			
9. Measles	a. _ _/_ _/_ _				
10. Mumps	a. _ _/_ _/_ _				
11. Rubella	a. _ _/_ _/_ _				

IV. Health Assessment

A. 12. Height: ___ ft. ___ in. ❐ Missing 13. Weight: __ __ __ lbs. __ __oz. ❐ Missing

B. 14. Vision ❐ Passed ❐ Failed ❐ Missing

	R	L	Both
15. Far	a. 20/ __ __	b. 20/ __ __	c. 20/ __ __
16. Near	a. 20/ __ __	b. 20/ __ __	c. 20/ __ __

17. With glasses ❐ Yes ❐ No ❐ Missing 18. Hearing ❐ Pass ❐ Fail ❐ Missing

C. 19. Hemoglobin/Hematocrit ❐ Normal ❐ Abnormal ❐ Missing
20. TB Skin Test ❐ Normal ❐ Abnormal ❐ Missing

D. 21. Please check any of the following illnesses the child has or has had:

a. ❐ None checked
b. ❐ No problems
c. ❐ Asthma
d. ❐ Bleeding Problems
e. ❐ Bone/Muscle Problems
f. ❐ Bowel Problems
g. ❐ Cancer/Leukemia
h. ❐ Convulsions/Seizures
i. ❐ Cystic Fibrosis
j. ❐ Cerebral Palsy
k. ❐ Dental Problems
l. ❐ Diabetes
m. ❐ Ear Infections
n. ❐ Heart Problems
o. ❐ Hearing Problems
p. ❐ Meningitis
q. ❐ Sickle Cell Anemia
r. ❐ Skin Problems
s. ❐ Speech Problems
t. ❐ Stomach Aches

E. 22. Does this child take medications on a regular basis? ❐ Yes ❐ No ❐ Missing