Attention Physicians and staff completing 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 on the NC Pre-K Health Assessment Form and state when you will be attempting a rescreen. If the child is still uncooperative and you could not get a pass or fail by the rescreen please state who you are referring the child to for further screening. Stating that the child is uncooperative cannot be accepted.

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 so much for your help and cooperation with completing these forms.

Emily Poag
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 PADRE - COMPLETE ESTA SECCIÓN

Child's Name/
Nombre del Niño: _____ _____ _____
(Last/ Apellido(s)) (First/ Primer Nombre) (Middle/ Segundo Nombre)

Gender/Género: ☐ M ☐ F

Date of Birth (M/D/YYYY)/ Fecha De Nacimiento (mes/dia/año): _____ / _____ / _____

School Name: **Gaston County NC Pre-K Program**

Hispanic or Latino Origin: ☐ Yes/Sí ☐ No/No

Race/ Raza: ☐ White/Blanco ☐ Black/Negro ☐ Asian/Asiático ☐ Hawaiian/Pacific Islander/ Hawaiano/Isleño del Pacífico ☐ Native American/Alaskan/ Nativo americano/Nativo de Alaska ☐ Unknown/Desconocido ☐ Other/Otro: _____

Home Address/Dirección de domicilio: _____

City/Ciudad: _____

State/Estado: _____

County/Condado: _____

Parent / Guardian Name/Nombre del Padre/Tutor: _____

Telephone Number(s) / Número(s) de teléfono:

Home/Casa: (_____) _____ - _____ Work/Trabajo: (_____) _____ - _____ Cell/Celular: (_____) _____ - _____

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties) / Preocupaciones de salud que deben compartirse con personas autorizadas (administradores escolares, maestros y otro personal escolar que requiera dicha información para realizar sus tareas asignadas):

HEALTH CARE PROVIDER - COMPLETE NEXT TWO (2) SECTIONS

NC Pre-K Required Screenings

Vision screening information:

☐ Pass ☐ Fail
☐ Rescreen in __ weeks/months
☐ Referred:

Concerns related to student's vision:

Hearing screening information:

☐ Pass ☐ Fail
☐ Rescreen in __ weeks/months
☐ Referred:

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 (WNL)
☐ 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)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Child Development and Early Education

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: