PPS-2K Rev. 1/06

St Thomas More Catholic School

Health Assessment/Immunization Form

PRE-K through 8th GRADE

Personal Data (*TO BE COMPLETED BY PARENT OR GUARDIAN*)

(Please Print Clearly)

Child's Name _____ _____ _____
(Last) (First) (Middle)

Birth Date: ___ / ___ / _____ (mm/dd/yyyy)

Address: _____ Phone: (___)_____

Parent/Guardian Name: _____

This assessment was completed by child's regular health care provider ____ yes ____ no. If no, *parent* please provide a copy to the child's regular health care provider.

Yes	No	
❑	❑	Do you have any concerns about your child's health, weight, development or behavior?
❑	❑	Has your child been evaluated for any health, weight, developmental or behavioral concerns?
❑	❑	Is there any family history of health, weight, developmental or social/emotional concerns?
❑	❑	Has your child had a dental exam by a dentist in the last 12 months?
❑	❑	Has your child had a well-child or preventive health exam in the last 12 months?

Comments: _____

Recommendations to School Personnel Based on Health Assessment

(TO BE COMPLETED BY HEALTH CARE PROFESSIONAL)

___ **Activity Level.** Evaluate need to modify activity level. Guidance: _____

___ **Allergy** ❑ food: _____ ❑ insect: _____ ❑ medicine: _____ ❑ other: _____
Type of allergic reaction: ❑ anaphylaxis ❑ local reaction
Response required: ❑ epi pen ❑ other: _____

___ **Developmental Evaluation.** Consider need for developmental evaluation. Guidance: _____

___ **Health-related adjustments to enhance school performance.** Evaluate need for adjustments.
Guidance: _____

___ **Medication**
___ Child takes medicine for specific health conditions:
List medication(s): 1. _____ 3 _____
2. _____ 4. _____
___ Medication must be given and/or available at school. **Requires School Medication Authorization form.**
___ School Medication Authorization Form complete (please **attach**)
___ Asthma Action Plan complete (please **attach**)

___ **Special Diet. Guidance:** _____

Comments: _____

Health Care Professional's Certification

I certify that the information on page 1 and page 2 of this form is accurate and complete.

Name Health Care Provider (**write legibly or stamp**): _____
Signature _____ Date: _____
Practice/Clinic Name & Address: _____
Phone Number: (___)_____ Fax Number: _____

Personal Data (*TO BE COMPLETED BY PARENT OR GUARDIAN*)

Child's Birthdate: ___ / __ / _____ (MM DD YYYY) Sex: ☐ 1 Male ☐ 2 Female

Race: ☐ 1 other non-White ☐ 2 White ☐ 3 Black ☐ 4 Am. Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Hispanic/Latino origin: ☐ 1Yes ☐ 2 No

County of Residence: _____ Zip Code: _____ School your child will be attending: _____

Child has: ☐ 1 Medicaid ☐ 2 Private insurance/HMO ☐ 3 Other: _____ ☐ 4 No insurance

Place where your child gets regular health care: ☐ 1 Health Department ☐ 2 Hospital Clinic ☐ 3 Community Health Center ☐ 4 Private Doctor/HMO ☐ 5 Other _____ ☐ 6 No regular place

Doctor/Practice Name: _____

Health Assessment (*TO BE COMPLETED BY HEALTH CARE PROFESSIONAL*)

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: ___/___/___

Weight: _____ lbs. Height: ___ ft. ___ in

Body Mass Index (BMI) - for age: _____

☐ 1 Normal (5%ile-<85%ile)
☐ 2 Underweight (<5%ile)
☐ 3 At-Risk (85%ile-95%ile)
☐ 4 Overweight (>95%ile)

Blood Pressure:
☐ 1 Within Normal Range
☐ 2 > 90th Percentile
_____ %ile
_____ (raw)

Physical Examination	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurologic	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Immunization Status (PROVIDE IMMUNIZATION RECORD– Form <u>will not be accepted</u> without record)

Immunizations are up-to-date ☐ 1 YES ☐ 2 NO

Pertinent Illnesses or Developmental Problems: *(Please check all that apply):*

☐ Allergy (specify in Recommendations above)
☐ Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Problems
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Convulsions/Seizures
☐ Cystic Fibrosis
☐ Dental Problems
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (daytime)
☐ Genetic Disorders
☐ Heart Problems
☐ Hearing Problems
☐ Lead (History of > 10 mcg/dL)
☐ Orthopedic Problems
☐ Prematurity (< 32 wks. EGA)
☐ Sickle Cell Anemia
☐ Speech/Language
☐ Vision Problems
☐ Other:
☐ none

Screening Results

Developmental

Tool Used:
PEDS 1 ☐
ASQ 2 ☐
IDI/CDI 3 ☐

	Within Normal Range 1	Concern Identified 2	Referred for Evaluation 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Hearing

Hearing		1000	2000	4000
	R			
	L			

Indicate Pass (P) or Refer (R) in each box. Refer is any failure at any frequency in either ear.
☐ With Hearing Aid (check if yes)
☐ Permanent Hearing Loss Previously Identified (check if yes)

Screen Used: ☐ 1 OAE ☐ 2 Audiometry
☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid.
Date of rescreen appt: _____
☐ 3 Referral to Audiologist/ENT (check if yes)

Vision

Stereo: ☐ 1 Pass ☐ 2 Fail				Test used:
Far	Both	R	L	
	20/	20/	20/	Test used:
With Glasses: ☐ 1 Yes ☐ 2 No				

☐ 1 Pass
☐ 2 Referral to Eye Doctor (check if YES)
(Refer if worse than 20/40 in either of both eyes, a two line difference between eyes, failed stereo, or unable to test.)

Comments: _____