Health & Human Resources

Name_____DOB_____Age_____Sex M F WT_____HT_____BP_____Temp_____Pulse_____Screen Date_____

Allergies: □ NKDA _____ Current Meds: □ None_____

Health condition(s) that may require care at school: _____

School Entry Requirements

□ **Vision Acuity Screen** (obj) R_____ L_____
Wears glasses □ Yes □ No

□ **Hearing Screen** (obj)
20 db@   25 db@
R ear:____500HZ   R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ   L ear:____1000HZ ____2000HZ _____4000HZ
Wears hearing aids □ Yes □ No

□ **Dental Screen**
Date of last dental visit_____
Water source_____ Fluoride □ Yes □ No
□ Current dental problems:_____

Developmental: √ Check those that apply
Gross Motor:
□ Walks, climbs, runs □ may be able to skip
□ Up/down stairs alternating feet, without support

Developmental: √ Check those that apply
Fine Motor:
□ Copies ▲ or ■   □ Prints some letters
□ Draws figure w/head, arms and legs   □ Dresses self
□ Has manual dexterity
Communication:
□ Able to recall parts of story
□ Fluent speech   □ Uses complete sentences
□ Speaks in short sentences   □ Uses future tense
□ Second language spoken at home
Cognitive:
□ Knows address and phone #
□ Can count on fingers   □ Follows 2-3 step instructions
□ Recognizes many letters of the alphabet
Social:
□ Listens to stories   □ Follows rules
□ Plays interactive games with peers
□ Elaborate fantasy play/make believe/dress up

Immunizations: □ UTD □ If not UTD, see attached record

Referrals: □ Developmental □ Dentist □ Vision
□ Hearing □ Blood lead 10> □ Other:

Provider signature required for validation.

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title □ See Progress Notes

**The information above the line is intended to be
released to meet the requirements of pre-k and
kindergarten screening.**

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses or visits to other providers:

Social/Family History: √ Check those that apply
□ No change
□ Family situation change

Parents working outside home? □ Mother □ Father
Child care? □ No □ Yes _____
Other changes since last visit:

Current Health Indicators: √ Check those that apply
□ No change
Changes since last visit:

School: Grade_____ □ Attends school regularly □ N/A
□ Ability to separate from parents_____
Likes most about school_____
Likes least about school_____

Family: □ Gets along with other family members

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination   □ Normal sleep patterns
□ Appropriate behavior

Nutrition: □ Normal eating habits
□ Vitamins_____
□ Passive smoking risk □ Yes □ No
Tuberculosis Risk: □ Low risk   □ High risk
□ Exposure to TB   □ Homelessness
□ Radiographic or clinical findings
□ Immigrant from areas with high prevalence
□ Residence/Travel in area with high prevalence
□ HIV infection or living with person(s) who are HIV+
□ Other risk factors
Lead Risk: □ Low risk   □ High risk
□ Lives in or regularly visits a house/child care facility
   built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery
   recycling plant or lives with an adult whose job or hobby
   involves exposure to lead?
□ Has a sibling or playmate with a history of elevated lead level?

Physical Examination: √=Normal limits
□ General appearance   □ Skin
□ Neurological   □ Reflexes
□ Head   □ Neck
□ Eyes   □ Strabismus
□ Nose   □ Ears   □ Throat
□ Lungs   □ Heart   □ Pulses
□ Abdomen   □ Genitalia
□ Back   □ Extremities

Abnormal Findings and Comments:
Possible signs of abuse: □ Yes □ No

Health Education:
□ Discussed   □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care,
sexuality, injury and violence prevention, social
competence, school entry, family relationships and
community interaction

Other:

Assessment: □ Well Child   □ Other diagnosis

Plan/Referrals:

Labs: □ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
□ Other referral(s)

Follow up/Next visit:
Additional comments: