Preschool Health Assessment Report

Parent Complete PERSONAL

1. DATA

Name of child :_____
(Last) (First) (Middle)

Birthdate:_____/___/____ **Sex:**_Male ____Female

Race:____White ____Black ___American Indian _____Asian _

_____Other:_ **Hispanic or Latino Origin:**_____Yes_____No

Place where you child gets regular health care:

____Health Department ____Emergency Room/Hospital ____Private Doctor/HMO

____Community Health Center ____No Regular Place ____Other _____

Yes	No	
___	___	Are you concerned about your child's health, development or behavior?
___	___	Does anyone in your family have a condition that has affected their development or behavior? If so, please explain: _____ _____
___	___	Has your child been seen by a doctor for any health development or behavior concern?
___	___	Has your child had a well-child visit or check-up in the last 12 months?
___	___	Has your child ever been to a dentist?
___	___	Do you have a family dentist?
___	___	Does your child speak and understand English?
___	___	Do you speak English in your home? If not, what language is spoken? _____
___	___	Does your child have siblings? If so, please list names and ages _____
___	___	Is your child potty trained?
___	___	Does your child play often with other children?
___	___	Has your child ever attended a preschool, playgroup, or mother's day out program?

PLEASE HAVE YOUR CHILD'S HEALTHCARE PROVIDER FILL OUT THE INFORMATION FOUND ON THE OTHER SIDE OF THIS FORM AND RETURN TO

SJV LEARNING AND GROWTH CATHOLIC PRESCHOOL OFFICE

16166 SOUTH HARRELLS FERRY ROAD

BATON ROUGE, LOUISIANA 70816

225-752-5356 Fax: 225-753-7965

Revised 10/2018

Health Care Provider

ATTN: HEALTH CARE PROVIDER-PLEASE READ

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the LA Board of Medical Examiners, a certified nurse practitioner, or a public health nurse. The health care provider must fill out the remainder of this form in its *entirety*.

2. IMMUNIZATION RECORD-ATTACH A COPY OF THE IMMUNIZATION RECORD

Are all immunizations complete at this time?_____Yes_____No

Immunization Record Attached:_____Yes_____No

Exempt from Immunizations: (Attach appropriate form)_____Religious_____Medical _____Delayed

3. HEALTH HISTORY, PERTINENT ILLNESSES, RISKS OR DEVELOPMENTAL PROBLEMS: *CHECK ALL THAT APPLY*

___Allergy	___ Diabetes	___Orthopedic Cond.
___Anemia	___Emotional	___Prematurity <32
___Asthma	___Constipation	___Seizures
___Attention/Learning	___Enuresis	___Sickle Cell Anemia_____Trait
___Behavioral	___Genetic Disorder	___Speech/Language
___Bleeding Disorder	___Heart Condition	___TB ___at risk
___Cancer/Leukemia	___Hearing Disorder	___Vision Disorder
___Cerebral Palsy	___Kidney Disorder	
___Cystic Fibrosis	___Obesity	

4. HEALTH ASSESSMENT: DATE OF ASSESSMENT_____/_____/_____WEIGHT:_____ HEIGHT:_____

5. RECOMMENDATIONS TO SCHOOL PERSONNEL BASED ON HEALTH ASSESSMENT

___No Recommendations, Concerns or Needs

___Developmental Concerns Identified

___Referral has been made for further evaluation. (please attach a copy of the referral)

___Health related recommendations to enhance school performance:_____

Medication:_____Must be made available at school Child takes the following medication(s): 1._____

2._____3._____4._____

Allergy:_____Food_____Insect_____Medicine_____Other:_____

Type of reaction: ____Anaphylaxis ____Local reaction

Response required:_____Epinephrine Auto-injector ____Other:_____ ____None

School Forms Attached: ____School Medication Authorization Form ___Diabetes Care Plan _____Asthma Action Plan

_____ Emergency Health Care Plan: _____

___Child requires a special diet: _____

Comments:

_____

_____

Provider Stamp Here

Provider's Name:_____Date:_____

Provider's Signature: _____

Practice/Clinic Name:_____

Practice/Clinic Address::_____

Practice/Clinic Phone:_____Fax:_____