

New Hampshire Early Childhood Health Assessment Record

FOR USE FROM BIRTH THROUGH GRADE 3

To Parent or Guardian: In order to provide the best experience for your child, early childhood providers and school staff must understand your child's health needs. This form requests information from you (Part I) which also will be helpful to the primary health care provider when he or she completes the health evaluation (Part II).

Part I: FAMILY INFORMATION AND HEALTH HISTORY (to be completed by parent or guardian)

Important: Complete this page BEFORE you give this form to your child's primary care provider.

Please print

Name of Child/Student (Last, First, Middle)	Birth Date	Sex	Primary Care Provider
Address (Street)		Town and ZIP Code	
Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number	

*If your child does not have health insurance, call 1-877-464-2447 (Children's Medicaid Unit)

Is your child currently enrolled in WIC? Yes / No Does your child have health insurance? Yes / No*

Please check "Yes" or "No" next to each question below. Use this checklist to talk to your child's primary care provider about your answers.

- 1 Yes No Do you have any questions or concerns about your child's health, development, or behavior?
If "Yes," be sure to discuss these with your child's primary care provider. You may also contact NH Watch Me Grow at your community's family resource center (for children < 6 years) or your school district (children 3 and older) for information about free screenings.
- 2 Yes No Do you have any concerns about your child's eating or sleeping habits?
- 3 Yes No Has your child had a dental exam in the past 6 months?
- 4 Yes No Does your child have any ongoing health problems (such as asthma, diabetes, or seizure disorder)?
- 5 Yes No Does your child have any allergies (to food, medication, insects, latex, etc.)?
- 6 Yes No Does your child require a special diet while in school or other early childhood program?
- 7 Yes No Does your child take any medications (daily or occasionally)?
- 8 Yes No Does your child have any difficulty with his/her vision, hearing, or speech?
- 9 Yes No In the past 12 months, has your child experienced any difficulty with wheezing or coughing?
- 10 Yes No In the past 12 months, have you been concerned about a change in your child's weight?
- 11 Yes No In the past 12 months, have you noticed any change in your child's appetite or thirst?
- 12 Yes No In the past 12 months, have you noticed that your child is urinating more frequently?
- 13 Yes No Has your child ever been hospitalized or had any operations, procedures, or special tests?

Explain any "yes" answers here. Give approximate dates for any hospitalizations, operations, or serious illnesses:

PERMISSION TO EXCHANGE INFORMATION

I, Name of Parent/Guardian, authorize and request my child's primary care provider to exchange information about my child's health and development as pertains to this form with the program/school listed below. The information may be provided by phone, fax, mail, or in person. I understand that the disclosed information will be considered confidential and will be used only for the health and educational benefit of my child and family. Except as needed to comply with federal and state regulations, it will not be re-disclosed to any other person, school, or agency without my consent. I understand that this form will expire in one year unless I choose to cancel my permission in writing before that time.

Prescott Farm Environmental Education Center

Name of Program/School Requesting Information

928 White Oaks Rd., Laconia, NH 03246

Program/School Mailing Address

(603) 366-5695

Program/School Telephone Number

(603) 366-5720

Fax Number

Signature of Parent/Guardian

Date

Signature of Witness

Date

Endorsed by the NH Department of Health and Human Services; the NH Department of Education; NH Women, Infants & Children Nutrition Program; Head Start; and the NH Pediatric Society



Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider who must be a licensed physician, nurse practitioner, or physician's assistant.

Name of Child/Student		Date of Assessment		PLEASE ATTACH COPY OF IMMUNIZATION RECORD																																																				
Birth Date		Date of Next Scheduled Assessment																																																						
Physical Examination	WT	<i>(must be taken within 60 days for WIC)</i>	lb / kg	Body Mass Index (BMI) <i>(if ≥ 2 years)</i>																																																				
	HT	<i>(must be taken within 60 days for WIC)</i>	in / cm	<input type="checkbox"/> 5-84th % ile <input type="checkbox"/> < 5th % ile <input type="checkbox"/> 85-94th % ile <input type="checkbox"/> ≥ 95th % ile																																																				
	HC	<i>(if ≤ 2 years)</i>	in / cm	BP <i>(if ≥ 3 years)</i>	/ <input type="checkbox"/> Within normal range <input type="checkbox"/> ≥ 95th % ile																																																			
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;">Normal</td> <td style="width: 15%; text-align: center;">Yes</td> <td style="width: 15%; text-align: center;">No</td> <td style="width: 15%; text-align: center;">Follow-up indicated</td> <td style="width: 30%;"></td> </tr> <tr> <td>HEENT</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td rowspan="8" style="vertical-align: top; font-size: small;">Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:</td> </tr> <tr> <td>Dental/Oral health</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cardiac</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Abdomen</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Back/Extremities</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Breasts/Genitalia</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Neurologic</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Skin</td> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>				Normal	Yes	No	Follow-up indicated		HEENT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:	Dental/Oral health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back/Extremities		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breasts/Genitalia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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Preventive Screening	HEARING	PLEASE NOTE: Objective hearing screening beginning at age 4 years is REQUIRED for Head Start																																																						
	Date performed: / /		L <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Method: <input type="checkbox"/> Audiometry																																																				
			R <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> OAE																																																				
	Was child referred for rescreen or further evaluation? Y Y <input type="checkbox"/> N <input type="checkbox"/>				Does child wear a hearing aid? Y <input type="checkbox"/> N <input type="checkbox"/>																																																			
	VISION	PLEASE NOTE: Objective vision screening beginning at age 3 years is REQUIRED for Head Start																																																						
	Date performed: / /		L 20/	Method: <input type="checkbox"/> Snellen <input type="checkbox"/> Other																																																				
		R 20/	<input type="checkbox"/> Tumbling E																																																					
Was child referred for rescreen or further evaluation? Y Y <input type="checkbox"/> N <input type="checkbox"/>				Does child wear glasses? Y <input type="checkbox"/> N <input type="checkbox"/>																																																				
LABS	PLEASE NOTE: Hgb or HCT values at ages 1 and 2 years, and lead levels at ages 1, 2, and 3-6 years are REQUIRED for Head Start																																																							
	HGB:	g/dL	HCT:	%	Date: / /																																																			
	HGB:	g/dL	HCT:	%	Date: / /																																																			
	Lead:	mcg/dL		Date: / /																																																				
	Lead:	mcg/dL		Date: / /																																																				
	Lead:	mcg/dL		Date: / /																																																				
	Is child at risk for TB?		N <input type="checkbox"/>	Y <input type="checkbox"/>																																																				
If yes, PPD result:		POS / NEG	Date: / /																																																					
DEVELOPMENTAL SCREENING <small>(e.g., ASQ, ASQ:SE, M-CHAT, PEDS)</small>	Date of screening:		/ /																																																					
	Screening tool(s) used:																																																							
	Typically developing:		Y	N	Referred																																																			
	Gross motor		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																			
	Fine motor		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																			
	Language/communication		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																			
	Problem-solving		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																			
Social/emotional		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																				
Special Needs	Chronic medical conditions/related surgeries?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Medications or treatments?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Allergies/sensitivities?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Behavioral issues/mental health diagnoses?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Limitations to physical activity?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Special equipment needs?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
	Special dietary requirements?		<input type="checkbox"/> No <input type="checkbox"/> es <input type="checkbox"/> Special care plan attached*																																																					
List special needs/considerations and medications below (other than in attached special care plans). Please attach Special Meals Prescription Form, if applicable.																																																								

Name, address, and telephone no. of primary health care provider (please print or use stamp):

Signature of Primary Health Care Provider _____ Date _____

*Please attach any special care plans or other information