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

Is your child currently enrolled in WIC? Yes / No

Does your child have health insurance? Yes / No*

**If your child does not have health insurance, talk to your primary care provider or visit https://nheasy.nh.gov*

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.

	Yes	No	
1	☐	☐	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	☐	☐	Do you have any concerns about your child's eating or sleeping habits?
3	☐	☐	Has your child had a dental exam in the past 6 months?
4	☐	☐	Does your child have any ongoing health problems (such as asthma, diabetes, or seizure disorder)?
5	☐	☐	Does your child have any allergies (to food, medication, insects, latex, etc.)?
6	☐	☐	Does your child require a special diet while in school or other early childhood program?
7	☐	☐	Does your child take any medications (daily or occasionally)?
8	☐	☐	Does your child have any difficulty with his/her vision, hearing, or speech?
9	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or coughing?
10	☐	☐	In the past 12 months, have you been concerned about a change in your child's weight?
11	☐	☐	In the past 12 months, have you noticed any change in your child's appetite or thirst?
12	☐	☐	In the past 12 months, have you noticed that your child is urinating more frequently?
13	☐	☐	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.

Bright Ideas Preschool & Learning Center
Name of Program/School Requesting Information

292 Route 101, Unit 5 Amherst, NH 03031
Program/School Mailing Address

Signature of Parent/Guardian

Date

Program/School Telephone Number

Fax Number

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

May 2012

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Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider—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	*(must be taken within 60 days for WIC)*	lb / kg	Body Mass Index (BMI) *(if ≥ 2 years)* ☐
HT	*(must be taken within 60 days for WIC)*	in / cm	☐ *5–84th % ile* ☐ *85–94th % ile* ☐ *< 5th % ile* ☐ *≥ 95th % ile*
HC	*(if ≤ 2 years)*	in / cm	BP *(if ≥ 3 years)* / ☐ Within normal range ☐ ≥ 95th % ile

	Normal Yes	Normal No	Follow-up Indicated
HEENT	☐	☐	☐
Dental/Oral health	☐	☐	☐
Cardiac	☐	☐	☐
Lungs	☐	☐	☐
Abdomen	☐	☐	☐
Back/Extremities	☐	☐	☐
Breasts/Genitalia	☐	☐	☐
Neurologic	☐	☐	☐
Skin	☐	☐	☐

Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:

Preventive Screening

HEARING

PLEASE NOTE: Objective hearing screening beginning at age 4 years is REQUIRED for Head Start

Date performed: / / L ☐ Pass ☐ Fail R ☐ Pass ☐ Fail *Method:* ☐ Audiometry ☐ OAE

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear a hearing aid? Y ☐ N ☐

VISION

PLEASE NOTE: Objective vision screening beginning at age 3 years is REQUIRED for Head Start

Date performed: / / L 20/ R 20/ Both 20/ *Method:* ☐ Snellen ☐ Tumbling E ☐ Other

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear glasses? Y ☐ N ☐

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 ☐ Y ☐

If yes, PPD result: POS / NEG Date: / /

DEVELOPMENTAL SCREENING *(e.g., ASQ, ASQ:SE, M-CHAT, PEDS)*

Date of screening: / /

Screening tool(s) used:

Typically developing:	Y	N	Referred
Gross motor	☐	☐	☐
Fine motor	☐	☐	☐
Language/communication	☐	☐	☐
Problem-solving	☐	☐	☐
Social/emotional	☐	☐	☐

Special Needs

Chronic medical conditions/related surgeries?	☐ No ☐ Yes ☐ Special care plan attached*
Medications or treatments?	☐ No ☐ Yes ☐ Special care plan attached*
Allergies/sensitivities?	☐ No ☐ Yes ☐ Special care plan attached*
Behavioral issues/mental health diagnoses?	☐ No ☐ Yes ☐ Special care plan attached*
Limitations to physical activity?	☐ No ☐ Yes ☐ Special care plan attached*
Special equipment needs?	☐ No ☐ Yes ☐ Special care plan attached*
Special dietary requirements?	☐ No ☐ Yes ☐ 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*