Personal Data

PPS-2K Rev. 1/11

PARENT COMPLETE

Child's Birthdate: ____ /____ 20 ____ (mm/dd/yyyy)

Sex: ◉ 1 Male ○ 2 Female

County of Residence: _____

Zip Code: _____

School your child will be attending:

_____

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

Race:
◉ 1 Other Non-White
○ 2 White
○ 3 Black
○ 4 American Indian
○ 5 Chinese
○ 6 Japanese
○ 7 Hawaiian
○ 8 Filipino
○ 9 Other Asian
○ 10 Unknown

Hispanic or Latino Origin: ○ 1 Yes ○ 2 No

Child has:
○ 1 Medicaid
○ 2 Private Insurance/HMO
○ 3 No Insurance
○ 4 Other: _____

***Doctor/Practice Name*:** _____

***Dentist Name*:** _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/____

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.

Immunizations - Attach a copy of the immunization record.

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

☐ Allergy
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of ≥10 mcg/dL) ☐ At-Risk ☐ Test done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other: _____
☐ None

Screening Results

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

Screening Tool Used:
☐ 1 OAE
☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT (check if yes)
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis ○ Pass ○ Fail
Far:	20/	20/	Acuity Test Used:

Was test performed with corrective lenses? ○ ***yes*** ○ ***no***

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 2 Referral to eye doctor (check if YES) Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

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

Body Mass Index (BMI) - for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (≥ 95%ile)

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

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

Comments: _____