North Valley Academy Pre-K
Preventative Health Care Examination Form

North Valley Academy requires a preventative health care examination of each child entering Pre K prior to final admission to the program. A qualified licensed physician, nurse practitioner, or physician assistant must complete the examination.

GENERAL STUDENT INFORMATION

Student's Name ____ Birth Date ______________
Last First Middle Initial

Height ______________ Weight ______________ Pulse ______________ BP ______/______

MEDICAL	Normal	Abnormal Findings
Head		
Eyes		
Ears		
Oral/Dental		
Chest		
Cardiac		
Respiratory		
Abdomen		
Bowel		
Bladder		
Neurological		
Back/Spine		
Arms/Legs		
Skin		
Metabolic		
Psycho/Social		
Other		

GENERAL QUESTIONS

Any health, growth or developmental concerns/limitations Pre K staff should be aware of? YES ____ NO ____

If yes, what? ____

Any activity/participation restrictions Pre K staff should be aware of? YES ____ NO ____

If yes, what? ____

Any medications/procedures required during the Pre K day? YES ____ NO ____

If yes, what? ____

Any other information that would assist the Pre K staff

____

____

____

DENTAL SCREEN

☐ Problem Identified: Referred for Treatment

☐ No Problem: Referred for Prevention

☐ No Referral: Already receiving dental care

DEVELOPMENTAL SCREEN

Assessed for	*Assessment Method*	*Within Normal*	*Concern Identified*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

RECOMMENDATIONS TO PRE-K PERSONNEL

Summary of Findings (Check One):

☐ **Well Child; no conditions identified of concern to school program activities**

☐ **Conditions identified that are important to schooling or physical activity** (please explain)

____

____

____

___ Allergy ☐ Food: ________ ☐ Insect: ________ ☐ Medicine: ________ ☐ Other: ________

Type of allergic reaction: ☐ Anaphylaxis ☐ Local Reaction Response required: ☐ None ☐ Epi Pen ☐ Other

___ Restricted Activity (please specify) ____________________

___ Developmental Evaluation ☐ Has IEP ☐ Further Evaluation Needed For: __________

___ Special Diet Specify ____________________

___ Special Needs Specify ____________________

HEALTH CARE PROFESSIONAL'S CERTIFICATION

Name ________________ Signature ________________ Date ________

Practice/Clinic Name ____________________

Address ____________________

Phone _____ - _____ - ______

Thank you so much for your time!!!