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!!!