

**FORT BRAGG SCHOOLS  
PREKINDERGARTEN PROGRAM HEALTH ASSESSMENT**

**STUDENT NAME:** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY** Title 10, United States Code, Section 3013  
**PRINCIPAL PURPOSE** Information is used by DA personnel to: (1) verify child health status and currency of immunization per admission requirements; (2) note special considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illness/conditions; (4) refer child for enrollment in Exceptional Family Member Program.  
**ROUTINE USES:** Information provided may be released IAV the Army's blanket routine uses contained in AR 340-21  
**DISCLOSURES:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in Fort Bragg Schools Early Childhood Program for 4 year olds.

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<b>NAME OF SPONSOR (Last, First, MI)</b>	<b>Telephone(home)</b>	<b>Telephone (duty)</b>
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Sponsor's Social Security #: \_\_\_\_\_ Child's Birth Order in Family: \_\_\_\_\_

**I. PERTINENT HEALTH HISTORY:**  
Problems during pregnancy - Please explain: \_\_\_\_\_

\_\_\_\_\_

Birth Weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Problems after birth/during first year: \_\_\_\_\_

\_\_\_\_\_

Birth Defects: \_\_\_\_\_

Other Illnesses or Injuries: \_\_\_\_\_

List any allergies this child has (e.g., food, insect stings, medicine, pollens, etc.) \_\_\_\_\_

\_\_\_\_\_

Please indicate the following that apply to your child:  
Convulsions/Seizures \_\_\_\_\_ Diabetes \_\_\_\_\_  
Vision Problems \_\_\_\_\_ Hearing Problems \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Frequent Ear Infections \_\_\_\_\_  
Injuries or Accidents \_\_\_\_\_  
Does this child take medication on a regular basis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, list medication and possible side effects: \_\_\_\_\_

Does medication need to be given at school? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, list frequency and duration: \_\_\_\_\_

Where does your child get regular health care? \_\_\_\_\_ Bragg Family Practice Clinic (Eutaw)  
\_\_\_\_\_ TMC Clinic # \_\_\_\_\_ Smoke Bomb Hill Clinic  
\_\_\_\_\_ Pope Air Base Clinic \_\_\_\_\_ Clark Clinic  
\_\_\_\_\_ Pediatrics, Womack Army \_\_\_\_\_ Robinson Clinic  
\_\_\_\_\_ Family Practice, Womack Army Medical Center  
\_\_\_\_\_ Other: \_\_\_\_\_

**II. HEALTH SCREENING (required): To be Completed by Doctor or Other Appropriate Health Personnel**

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Percentile \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Percentile \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_/\_\_\_\_\_

**SCREENING**

**1. Vision**

R L Both  
 Far 20/\_\_\_\_ 20/\_\_\_\_ 20/\_\_\_\_  
 Near 20/\_\_\_\_ 20/\_\_\_\_ 20/\_\_\_\_  
 W/Glasses \_\_\_\_\_ Yes \_\_\_\_\_ No

**2. Hearing (Pass \_\_\_\_\_ or Fail \_\_\_\_\_)**

Pure Tone: \_\_\_\_\_ db level (usually 20 db)  
 500 1000 2000 4000  
 R  
 L

**3. Development (optional)**

\_\_\_\_\_ Within Normal Range

Tests Used \_\_\_\_\_  
 \_\_\_\_\_ Needs Follow-up

Hemoglobin/Hematocrit (if indicated) \_\_\_\_\_

\_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

TB Skin Test (if indicated) \_\_\_\_\_

\_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

Review any medical, dental, developmental conditions or disabilities which this child has and the extent to which these conditions might affect them.

Please Indicate (N) Normal (A) Abnormal Comment by Number:

- |                             |                              |
|-----------------------------|------------------------------|
| 1. Appearance _____         | 8. Chest/Lungs _____         |
| 2. Skin _____               | 9. Heart _____               |
| 3. Eyes _____               | 10. Abdomen _____            |
| 4. Ears _____               | 11. Musculoskeletal _____    |
| 5. Nose _____               | 12. Neurological _____       |
| 6. Throat _____             | 13. Nutritional Status _____ |
| 7. Mouth, Teeth, Gums _____ | 14. Other _____              |

**III. IMMUNIZATIONS (To be Completed by Doctor or Other Appropriate Health Care or School Personnel)**

**RECORD OF IMMUNIZATION (Enter date of EACH dose - Month/Day/Year)**

VACCINE	#1	#2	#3	#4	#5
DTaP					
*DT					
Polio					
Hib					
MMR					
Hep. B					
Varicella					
Other					

\*If given DT, must have "Allergy to Pertussis" written by doctor on this form or other reason why P not given.

**IV. RECOMMENDATIONS TO SCHOOL**

List any other health considerations for this child while in school: \_\_\_\_\_

Signature of Doctor/Health Care Provider

Date

Address

Phone Number