

# 2019-2020

## NASH/EDGECOMBE PRE-K APPLICATION FORM

**To participate in these pre-kindergarten programs your child must be four years old on or before August 31<sup>st</sup> of the current program year and must meet one or more of the following requirements:**

- Family's gross income is at or below 75% of the State Median Income level
- Child has an identified developmental disability
- Child has Limited English Proficiency (LEP) as indicated by the family and/or child speaking limited or no English in the home
- Child has an educational need as indicated by the child's performance results on an approved developmental screening or in an existing Individualized Education Plan (IEP)
- Child has a chronic health condition as indicated by the diagnosis from a professional health care provider
- Child and family are identified as homeless
- Child is a member of an eligible military family

**\*\*Determination of eligibility does not guarantee a placement in a pre-k program. Placement is also determined by availability of funds\*\***

**Please complete the FULL application and include the following attachments:**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Certified Birth Certificate</li> <li><input type="checkbox"/> 30 consecutive days of paystubs for the child's parents/guardians or a completed wage form signed by the employer (pay information must be no more than two months prior to the date on the application)</li> <li><input type="checkbox"/> Copy of most recent health assessment/well-child visit report</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Written documentation of any other sources of income: Social Security (SSA), SSI Disability, Child Support, etc.</li> <li><input type="checkbox"/> Copy of current immunization record</li> <li><input type="checkbox"/> Two (2) proofs of Residence (Ex. current utility bill, (gas, water, lights only), lease agreement, mortgage or property tax, driver's license)</li> </ul> |
|---|--|

**Pre-K is available in a variety of settings in Nash and Edgecombe counties, including private child care centers, Head Start, and public schools. The following is a list of Pre-K providers for 2019-2020 – Please review the list and indicate your first, second, and third site preferences.**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• <b>AJ Richardson Head Start</b> – Rocky Mount</li> <li>• <b>Old Carriage Road Head Start</b> – Rocky Mount</li> <li>• <b>Edgecombe County Public Schools</b></li> <li>• <b>Nash-Rocky Mount Public Schools</b></li> <li>• <b>Foundation Builders Academy</b> – Rocky Mount</li> <li>• <b>His Majesty's Children #2</b> – Tarboro</li> <li>• <b>Joyland Preschool</b> – Nashville</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Little Grown Ups Child Care</b> – Battleboro</li> <li>• <b>Peachtree Playschool</b> – Spring Hope</li> <li>• <b>St. Stephen's Loving Daycare</b> – Rocky Mount</li> <li>• <b>Stepping Stone Preschool and Child Care</b> – Nashville</li> <li>• <b>Think and Grow Child Care Center #3</b> – Tarboro</li> <li>• <b>Victory Learning Academy</b> – Rocky Mount</li> </ul> |
|--|--|

**1st Preference:** \_\_\_\_\_ **2nd Preference:** \_\_\_\_\_ **3rd Preference:** \_\_\_\_\_

**Please review all information to ensure you have filled out the form completely. You must sign below.**

The Early Care & Education programs and agencies that may receive a copy of this form include:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• The Down East Partnership for Children</li> <li>• Nash/Edgecombe NC Pre-Kindergarten Programs</li> </ul> | <ul style="list-style-type: none"> <li>• Nash/Edgecombe Public School Pre-Kindergarten Programs</li> <li>• N.E.E.D, Inc. - Head Start</li> </ul> |
|---|--|

I give permission for my child to be assessed and referred to the Early Care & Education programs and agencies listed above, by forwarding to the appropriate program a copy of this form and any other necessary information. Representatives from any of the indicated Early Care & Education programs and agencies have my permission to confirm all of the information on this form.

I understand that additional information may be requested after my eligibility for a particular program has been determined.

I certify that all of the information above is subject to verification, is true and correct and that all income is reported to the best of my ability.

**Signature of Parent/Guardian completing this form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*\*If guardian signs, official documentation of guardianship will be required.\**

## PARENT/GUARDIAN INFORMATION

**FIRST PARENT/GUARDIAN – Child must be living in the same household as the person(s) listed below.**

Parent/Guardian Name: _____	
Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian/Custodian <input type="checkbox"/> Other: _____	
Home Address: _____ <i>(Please include zip)</i>	Mailing Address: _____ <i>(If different than home – Please include zip)</i>
County You Live In: <input type="checkbox"/> Nash <input type="checkbox"/> Edgecombe <input type="checkbox"/> Other _____	Phone Number: _____ Second Phone Number: _____
Email address: _____	
Ethnicity: Are you of Latino/Hispanic descent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <i>(please check all that apply)</i> <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Employment/School Status: _____ <i>(please check all that apply)</i>	<b>** If you are employed you must provide 30 days of pay stubs or have your employer complete the attached wage form.</b>  <b>**Self-employed individuals may submit W-2 tax form from previous year.</b>

**Is there another parent or guardian that lives in the home with the child?**  YES  NO  
*\*\*If there is not a second parent in the home you must mark "NO" to avoid having an incomplete application\*\**

**SECOND PARENT/GUARDIAN - You must complete information for each parent in the household.**

Parent/Guardian Name: _____	
Relationship to Child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian/Custodian <input type="checkbox"/> Other: _____	
Ethnicity: Are you of Latino/Hispanic descent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <i>(please check all that apply)</i> <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Employment/School Status: _____ <i>(please check all that apply)</i>	<b>** If you are employed you must provide 30 days of pay stubs or have your employer complete the attached wage form.</b>  <b>**Self-employed individuals may submit W-2 tax form from previous year.</b>

### PARENT/GUARDIAN MILITARY STATUS

Does this child have a parent/guardian who is an active duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this child have a parent/guardian who was injured and/or is receiving military disability retirement or was killed while serving on active military duty? <input type="checkbox"/> Yes <input type="checkbox"/> No

# CHILD INFORMATION

Please complete information for each child that needs Pre-K services.

## CHILD #1

<b>Child's Full Name:</b> <i>(as on birth certificate)</i> _____		
<b>Child's Date of Birth:</b> _____	<b>Child's Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Child's Ethnicity:</b> Is child of Latino/Hispanic descent? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Child's Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <i>(please check all that apply)</i> <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____		<b>Who does the child live with?</b> <b>Family Status:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother & Father <i>(check one only)</i> <input type="checkbox"/> Legal Guardian/Custodian <input type="checkbox"/> Other: _____

### CHILD CARE INFORMATION

#### What is your child's current child care status?

- Enrolled in a child care facility (center or home)  
Name of facility: \_\_\_\_\_
- Previously/no longer enrolled in a child care facility
- Child cared for by friend, neighbor, or family member
- Parent stays home with child

#### Which best describes your child care financial assistance status?

- Receiving assistance with child care from:  
 DEPC Scholarship Program  
 Department of Social Services  
 NEED/Head Start  
 Other: \_\_\_\_\_
- Not receiving assistance with child care (I pay full cost)

### SPECIAL NEEDS AND SERVICES

**Does your child have a developmental or educational challenge?**  Yes  No  Don't know  
If yes, please explain and attach appropriate documentation: \_\_\_\_\_

**Does your child have a physical challenge or chronic illness?**  YES  NO  
If yes, please explain and attach appropriate documentation: \_\_\_\_\_

**Does your child have an Individualized Education Plan (IEP)?**  YES  NO  Don't know

## CHILD #2

<b>Child's Full Name:</b> <i>(as on birth certificate)</i> _____		
<b>Child's Date of Birth:</b> _____	<b>Child's Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Child's Ethnicity:</b> Is child of Latino/Hispanic descent? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Child's Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <i>(please check all that apply)</i> <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____		<b>Who does the child live with?</b> <b>Family Status:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother & Father <i>(check one only)</i> <input type="checkbox"/> Legal Guardian/Custodian <input type="checkbox"/> Other: _____

### CHILD CARE INFORMATION

#### What is your child's current child care status?

- Enrolled in a child care facility (center or home)  
Name of facility: \_\_\_\_\_
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 DEPC Scholarship Program  
 Department of Social Services  
 NEED/Head Start  
 Other: \_\_\_\_\_
- Not receiving assistance with child care (I pay full cost)

### SPECIAL NEEDS AND SERVICES

**Does your child have a developmental or educational challenge?**  Yes  No  Don't know  
If yes, please explain and attach appropriate documentation: \_\_\_\_\_

**Does your child have a physical challenge or chronic illness?**  YES  NO  
If yes, please explain and attach appropriate documentation: \_\_\_\_\_

**Does your child have an Individualized Education Plan (IEP)?**  YES  NO  Don't know

## ADDITIONAL INCOME INFORMATION

List the amounts of the following income sources that you receive - write in \$0 if none is received.

Veteran's Benefits: \$ _____ per month	Unemployment Benefits: \$ _____ per month
Social Security (SSA): \$ _____ per month	Workers' Compensation: \$ _____ per month
SSI Disability: \$ _____ per month	Other: _____ \$ _____ per month
Child Support: \$ _____ per month	Other: _____ \$ _____ per month

\*\*You must provide written documentation for all additional income sources\*\*

## HOUSEHOLD INFORMATION

**\*\*Please list EVERY person living at the home address reported on this application, including the child\*\***

Name	Date of Birth	Relationship to Child
<i>Example: Jane Smith</i>	<i>01/01/1988</i>	<i>Mother</i>

**Total number of family members in the home (including child):** \_\_\_\_\_

**What language is spoken in the home most of the time?**

- English  
  Spanish  
  Arabic  
  Chinese  
  Hindi  
  Vietnamese  
  Other: \_\_\_\_\_ (please specify)

**Which best describes your family's current living situation:**

- |   |   |
|---|---|
| <input type="checkbox"/> Permanent                              | <input type="checkbox"/> Hotel/Motel                      |
| <input type="checkbox"/> Homeless or Emergency Homeless Shelter | <input type="checkbox"/> Hospital for 30 days or under    |
| <input type="checkbox"/> Battered Women and Children Shelter    | <input type="checkbox"/> Lack permanent nighttime address |

## WAGE FORM NASH/EDGECOMBE PRE-K APPLICATION

In order to determine eligibility for Nash/Edgecombe pre-kindergarten services it is necessary for you to provide proof of income.

**\*\*If you do not have paystubs**, please have your **current employer complete and sign** the following form.

Please list gross wages for 30 days prior to the current month. Please complete for **each** parent/guardian.

**PARENT/GUARDIAN #1:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Employer Phone #:** \_\_\_\_\_

**Paycheck received:**  Once per week  Every two weeks  Twice per month (ex. 1<sup>st</sup> & 15<sup>th</sup>)  Once per Month

**Please complete using information from the last 30 days – Do Not Include Overtime**

Pay Period	Gross Earnings (BEFORE deductions and WITHOUT overtime)
<i>Example: 5/12/18 – 5/25/18</i>	\$1,234.56

**Employer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer/Company:** \_\_\_\_\_

**PARENT/GUARDIAN #2:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Employer Phone #:** \_\_\_\_\_

**Paycheck received:**  Once per week  Every two weeks  Twice per month (ex. 1<sup>st</sup> & 15<sup>th</sup>)  Once per Month

**Please complete using information from the last 30 days – Do Not Include Overtime**

Pay Period	Gross Earnings (BEFORE deductions and WITHOUT overtime)
<i>Example: 5/12/18 – 5/25/18</i>	\$1,234.56

**Employer's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer/Company:** \_\_\_\_\_

(Intentionally Blank)

**NASH/EDGECOMBE  
PRE-KINDERGARTEN HEALTH ASSESSMENT REPORT**

**PARENT COMPLETE**

**Personal Data** *\*Please bring your child's shot records with you to this visit\**

Please Print Clearly – See other side for more required information. Please present completed form to your child's school.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_ (mm/dd/yyyy)

(Last) (First) (Middle)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Yes No

- Are you concerned about your child's health, weight, development, or behavior?
- Does anyone in your family have a condition that has affected their health, weight, development, or behavior? **(Please explain in the comments section)**
- Has your child been seen by a provider for any health, weight, development, or behavior concern?
- Has your child had a dental exam by a dentist in the last 12 months?
- Has your child had a well-child visit or check-up in the last 12 months?

Comments: \_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH CARE PROVIDER COMPLETE**

**Recommendations to School Personnel Based on Health Assessment**

- No Recommendations, Concerns, or Needs  Requesting School Follow Up
  - Medication
    - Child takes medication for specific health conditions List Medications: 1. \_\_\_\_\_ 3. \_\_\_\_\_
    - Medication must be given and/or available at school 2. \_\_\_\_\_ 4. \_\_\_\_\_
  - Allergy
    - Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Medicine: \_\_\_\_\_  Other: \_\_\_\_\_
    - Type of allergic reaction:  Anaphylaxis  Local Reaction Response Required:  Epinephrine Auto-Injector  Other: \_\_\_\_\_  None
  - Developmental Concerns Identified – Child needs referral to school support team for further evaluation. **(See comments below)**
  - Special Diet
    - Guidance: \_\_\_\_\_
  - Health-Related Recommendations to Enhance School Performance *(For example: sitting near the front of classroom, special equipment needs).*
    - Please specify: \_\_\_\_\_
  - School Health Forms Attached
    - School Medication Authorization Form  Diabetes Care Plan  Asthma Action Plan  Health Care Plan(s) List Condition \_\_\_\_\_
- Comments: \_\_\_\_\_  
\_\_\_\_\_

Was this assessment completed in the child's regular health care provider's office?  Yes  No  
*If no, please provide a copy to the child's parent to give to the child's regular health care provider.*

**Health Care Professional's Certification – Attach a copy of the immunization record. Complete ALL screenings.**

*I certify that the information on this form is accurate and complete to the best of my knowledge.*

**Provider Stamp Here**

Provider's Name: \_\_\_\_\_  
 Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Practice/Clinic Name: \_\_\_\_\_  
 Practice/Clinic Address: \_\_\_\_\_  
 Practice Phone : \_\_\_\_\_ Fax: \_\_\_\_\_

**Personal Data**

Child's Birth Date: \_\_\_/\_\_\_/20\_\_\_ (mm/dd/yyyy)

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

County of Residence: \_\_\_\_\_ Zip Code: \_\_\_\_\_

School your child will be attending: \_\_\_\_\_

Sex:  1 Male  2 Female

Hispanic or Latino Origin:  1 Yes  2 No

Child has:  1 Medicaid  2 Private Insurance/HMO  3 No Insurance  4 Other: \_\_\_\_\_

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

Doctor/Practice Name: \_\_\_\_\_

Dentist Name: \_\_\_\_\_

**Date of Health Assessment:** \_\_\_/\_\_\_/\_\_\_ - Assessment must be completed no more than 12 months prior to child's first day of Pre-K  
*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)

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

**Screening Results – Screenings MUST be completed and scored for ALL children who may be enrolling in an NC Pre-K program.**

Developmental	Hearing	Vision																																																
<p><b>Screening Tool(s) Used:</b> <input type="checkbox"/> 1 PEDS <input type="checkbox"/> 4 PSC  <input type="checkbox"/> 2 ASQ <input type="checkbox"/> 5 ASQ-SE</p> <p style="text-align: center;">Within    Concern    Referred to Normal    Identified    Specialist</p> <table border="0" style="width:100%; text-align: center;"> <tr> <td style="width:33%;"><b>Developmental Domains:</b></td> <td style="width:11%;"><b>1</b></td> <td style="width:11%;"><b>2</b></td> <td style="width:11%;"><b>3</b></td> </tr> <tr> <td>Emotional/Social</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Problem Solving</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Language/Communication</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Fine Motor Skills</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Gross Motor Skills</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p><b>Comments:</b> _____</p>	<b>Developmental Domains:</b>	<b>1</b>	<b>2</b>	<b>3</b>	Emotional/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Language/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gross Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Hearing</th> <th style="width:15%;">1000 Hz</th> <th style="width:15%;">2000 Hz</th> <th style="width:15%;">4000 Hz</th> </tr> </thead> <tbody> <tr> <td>Right</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><i>Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at &gt;20dB.</i></p> <p><b>Screening Tool Used:</b> <input type="checkbox"/> 1 OAE <input type="checkbox"/> 2 Audiometry</p> <p><input type="checkbox"/> 1 Pass  <input type="checkbox"/> 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.  <input type="checkbox"/> 3 Referral to audiologist/ENT (<b>check if YES</b>)  <input type="checkbox"/> 4 Child has previously diagnosed hearing loss. Screening is not necessary.</p>	Hearing	1000 Hz	2000 Hz	4000 Hz	Right				Left				<p><b>Please remember that vision screening is not a substitute for a comprehensive eye examination.</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;"></th> <th style="width:15%;">Right</th> <th style="width:15%;">Left</th> <th style="width:15%;">Stereopsis</th> <th style="width:15%;">Pass</th> <th style="width:15%;">Fail</th> </tr> </thead> <tbody> <tr> <td>Far:</td> <td style="text-align: center;">20/</td> <td style="text-align: center;">20/</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p><b>Acuity Test Used:</b></p> <p><b>Was test performed with corrective lenses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> 1 Pass (Acuity, Stereopsis, &amp; Symptoms)  <input type="checkbox"/> 2 Referral to eye doctor (<b>check if YES</b>) 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.  <input type="checkbox"/> 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.</p>		Right	Left	Stereopsis	Pass	Fail	Far:	20/	20/		<input type="checkbox"/>	<input type="checkbox"/>
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**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<sup>th</sup> percentile (\_\_\_\_%ile)

- |                  |                          |                          |
|------------------|--------------------------|--------------------------|
| HEENT            | Normal                   | Abnormal                 |
| Dental/Oral      | 1                        | 2                        |
| Lungs            | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac          | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdomen          | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological     | <input type="checkbox"/> | <input type="checkbox"/> |
| Back/Extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital          | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin             | <input type="checkbox"/> | <input type="checkbox"/> |

**Comments:** \_\_\_\_\_