PART I HEALTH ASSESSMENT

To be completed by parent/guardian

Student's Name (Last, First, Middle)	Birthdate	Grade

Address | Phone Number

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone Number
Name: Address:

When was the last time your child had a physical exam? Month Year

When was the last time your child had a dental exam? Month Year

Where do you usually take your child for dental care? Phone Number
Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any of the following? Please check or no below.

	Yes	No	Comments
Anaphylaxis or severe allergic reactions			
Allergies (Foods, Insects, Medications, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavioral or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental Problems			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication? ☐ No ☐ Yes
If yes, name(s) of medications:____

Will your child require any medication to be administered in school? ☐ No ☐ Yes
If yes, name(s) of medications:____

Will your child require any emergency medications (epinephrine auto-injectors, inhalers, glucagon, Diastat, nebulized medication, etc.) to be administered at school? ☐ No ☐ Yes If yes, please list____

Will your child require any special treatments (G-tube feedings, catheterizations, etc.) to be administered at school? ☐ No ☐ Yes
If yes, please list____

Parent/Guardian Signature Date

PART II SCHOOL HEALTH ASSESSMENT

To be completed ONLY by authorized health care provider

Student's Name (Last, First, Middle)	Birthdate	Grade

1. Does the child have a diagnosed medical condition? ☐ No ☐ Yes

Specify____

____

2. Does the child have a health condition which may require EMERGENCY ACTION while at school? (e.g. seizure, severe allergic reaction/anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please work with the school nurse to develop an emergency plan. ☐ No ☐ Yes

Specify____

____

3. Are there any abnormal findings on evaluation for concern? ☐ No ☐ Yes

Specify____

EVALUATION FINDINGS/CONCERNS

PHYSICAL EXAM	WNL	ABNL	Area of concern	HEALTH ARE OF CONCERN	Yes	No
Head				Attention Deficity/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings/health concerns.)

4. **RECORD OF IMMUNIZATIONS:** Immunization records are to be completed and attached by an authorized health care provider.

5. Is the child on medication? If yes, indicate medication and diagnosis. ☐ No ☐ Yes

____

Medication Authorization Forms, Emergency Care plans, self administer and self carry authorization forms, etc. must be completed for medication administration in school.

6. Should there be any restriction of physical activity in school? If yes, please specify nature and duration of restriction. ☐ No ☐ Yes

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7. Screenings	**Results (actual value, or positive/negative)**	**Date Taken**
Tuberculin Test		
Blood Pressure/Heart Rate		
Height		
Weight		
BMI %tile		
Blood Least Testing		

PART II SCHOOL HEALTH ASSESSMENT (continued)
To be completed ONLY by authorized health care provider

(Student Name)____ has had a complete physical examination and has:

☐ No evident problem that may affect learning or full school participation ☐ Problems noted above

Additional Comments:

Name of Authorized Health Care Provider (Type or Print)	Phone Number	Authorized Health Care Provider Signature	Date