

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year:

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To Parent or Guardian:

The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential. PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)			Birth Date	e	Sex	School
Address (Street)						
Home Telephone Number: Cell Pho Name of Parent/Guardian (Last, First Mid Transportation Bus Rider Bus Number:	Car Rider		Needs Bu	Grade		Teacher/Homeroom Work Phone Number: ☐ After School
	Part I	 Health Inform 	ation			
Place your child receives health care: Physician's Name: Address: Phone: Community Health Center Health Department Hospital Clinic No Regular Place Private Doctor /HMO	□ ALL KIDS □ Medicaid □ No Insura □ Other □ Private In	ance		Dentist' Address Phone:_ □ Com □ Heal □ Hosp □ No F	s Name s: munity Ith Dep Dital Cli	
Part II – Medical His	tory Medica	l Equipment /Pı	rocedur	es Re	quire	d at School
Catheter	□ Nebulizer 7	reatments 🗆 O	xygen Si	upplem	ent	□ Tracheostom
Vagal Nerve Stimulator (VNS)	□ Ventilator	□ Wheelchair	□ Walk	er		
Other Please explain:						

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.





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	School Year:		
	Part III – Medical History		
□ YES □ NO	KNOWN HEALTH PROBLEMS		
	If NC go directly to the bottom of the page and provide parent/guardian signature		
	IT too, and diagnosed by a physician, answer each question below		
□ YES □ NO	Attention Deficit Disorder (ADD)		
D YES D NO	Attention Deficit Hyperactivity Disorder (ADHD)		
	Requires medication At school At Home		
O YES O NO	Allergies:		
,	Food		
	Insects		
	u charonmental		
	Other:		
□ YES □ NO	Asthma Uses an inhaler at school Uses an inhaler at home		
D YES D NO			
D 1E3 D NO	Blood/Bleeding Problems: Hemophilia, Von Willebrand's, Other		
v	□ Requires medication Please explain:		
□ YES □ NO	Fraguent Nego Plander Planes and in		
□ YES □ NO	Frequent Nose Bleeds: Please explain Cancer/Leukemia: Please explain		
□ YES □ 'NO	Cerebral Palsy: Please explain		
□ YES □ NO	Cystic Fibrosis: Please explain		
D YES D NO	Dental Problems: Please explain:		
□ YES □ NO	Disheter T. A. Bill.		
	E 1/odestop stippint of goldon		
•	☐ Insulin pump☐ Glucagon order		
• .1	□ Type 2 Diabetes □ Managed with diet □ Oral medication		
TYES NO	Emotional/Behavioral/Psychological: Please explain:		
O YES O NO	Gastrointestinal/Stomach Problems: Please explain:		
D YES D NO	Genetic / Rare Disorders: Please explain:		
D YES D NO	Headaches: Please explain: Hearing Problems: Right Ear Rearing Problems: Right Ear Right Ear		
	Hearing Problems: □ Right Ear □ Left Ear □ Both ears □ Hearing loss □ Hearing aid □ Tubes □ Cochlear Implant		
D YES D NO	Heart Condition: Activity restrictions: Medications taken at home:		
	Please explain:		
D YES D NO	Hypertension (High Blood Pressure): Please explain:		
D YES D NO	Juvenile Arthritis/Bone-Joint Problems: Please explain:		
D.YES D NO	Kidney/ Bladder/ Urinary Problems: Please explain:		
TYES INO	Scoliosis: No Treatment Wears Brace Surgery Family History		
□ YES □ NO	Seizures/Convulsions: Type of seizure:		
	Medications: □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other		
- VEC - NO	riease explain;		
D YES D NO	Skutt = \(\text{P} \) church = \(\text{P} \)		
I YES I NO	Shunt: UVP shunt Please explain:		
D YES D NO	Spina Bifida: Special Diet: Please explain:		
□ YES □ NO			
D YES D NO	Vision Problems: Wears glasses Wears contacts Other Medical Conditions: Please include any medications taken at home only.		
	medications taken at home only.		
	Required Signatures		
Cimpolina			
orgrature of parel	nt(s) or guardian:Date:		
Signature of scho	ol nurse:		