PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student Full Name	Birthdate Mo. day Yr.	Sex M/F	Name of School	Grade

1. Does the child have a diagnosed medical condition?

   NO YES______________________________

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problems, diabetes, heart problem, or other problem) If yes, please Describe. Additionally, please "work with your school nurse to develop an emergency plan".

   NO YES______________________________

3. Are there any abnormal findings in evaluation for concern?

EVALUATION FINDINGS/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustments		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/ Orthopedic				Nutrition		
Neurological				Physical Illness/Impairments		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

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4.RECORD OF IMMUNIZATION-DHMH 896 is required to be completed by health care provider or a computer generated Immunization record must be provided.

5. Is the child on medication? If yeas, indicate medication and diagnosis.

NO YES____

(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

NO YES____

7.**Screenings**	**Result**	**Date Taken**
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	____Optional	

PART II - SCHOOL HEALTH ASSESSMENT Continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name)____ has had a complete physical examination and has:

( )No evident problem that may affect learning ot full school participation or

( )Problems noted above

Additional Comments:

Date:__________________________

Physician/Nurse Practitioner (Print) Phone No# Physician/Nurse Practitioner Signature

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