

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

Part II - Medical History Medical Equipment/Procedures Required at School

Other Please explain: _____
 Vagal Nerve Stimulator (VNS) Ventilator Wheelchair Walker
 Catheter Gastric Tube Nebulizer Treatments Oxygen Supplement Tracheostomy

Part I - Health Information

Preferred Hospital:
 Place your child receives health care: _____
 Physician's Name: _____
 Address: _____
 Phone: _____
 Private Doctor/HMO
 No Regular Place
 Hospital Clinic
 Health Department
 Community Health Center

Your child's Insurance Information:
 ALL KIDS
 Medicaid
 No Insurance
 Other _____
 Private Insurance

Place your child receives dental care: _____
 Dentist's Name: _____
 Address: _____
 Phone: _____
 Private Dentist/HMO
 No Regular Place
 Hospital Clinic
 Health Department
 Community Health Center

Bus Rider Bus Number: _____
 Car Rider
 Special Needs Bus
 After School

Name of Student (Last, First, Middle) _____
 Address (Street) _____
 Home Telephone Number: _____
 Cell Phone Number: _____
 Additional Phone Number: _____
 Grade _____
 Teacher/Homeroom _____
 Name of Parent/Guardian (Last, First Middle) _____
 Work Phone Number: _____
 Transportation: _____

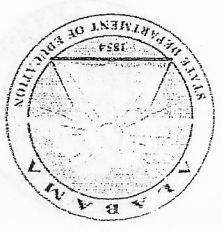
To Parent or Guardian:
 The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

School Year: _____

ALABAMA STATE DEPARTMENT OF EDUCATION
HEALTH ASSESSMENT RECORD



ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD



Part III - Medical History

KNOWN HEALTH PROBLEMS YES NO
 If you go directly to the bottom of the page and provide parent/guardian signature
 Attention Deficit Disorder (ADD) YES NO
 Attention Deficit Hyperactivity Disorder (ADHD) YES NO
 Requires medication At school At Home

Allergies: YES NO
 Food Insects Environmental Medications Other: _____
 Asthma YES NO
 Uses an inhaler at school Uses an inhaler at home
 Blood/Bleeding Problems: Hemophilia, Von Willebrand's, Other
 Requires medication Please explain: _____

YES NO
 Frequent Nose Bleeds: Please explain _____
 Cancer/Leukemia: Please explain _____
 Cerebral Palsy: Please explain _____
 Cystic Fibrosis: Please explain _____
 Dental Problems: Please explain _____
 Diabetes Type 1 Diabetes Monitors Blood Sugars at school Requires Insulin at school
 Type 2 Diabetes Managed with diet Oral medication
 Glucagon order Insulin pump

YES NO
 Emotional/Behavioral/Psychological: Please explain _____
 Gastrointestinal/Stomach Problems: Please explain _____
 Genetic / Rare Disorders: Please explain _____
 Headaches: Please explain _____
 Hearing Problems: Right Ear Left Ear Both ears Hearing loss Hearing aid
 Tubes Cochlear Implant
 Heart Condition: YES NO
 Activity restrictions: Medications taken at home: _____

YES NO
 Hypertension (High Blood Pressure): Please explain _____
 Juvenile Arthritis/Bone-Joint Problems: Please explain _____
 Kidney/ Bladder/ Urinary Problems: Please explain _____
 Scoliosis: YES NO
 No Treatment Wears Brace Surgery Family History
 Seizures/Convulsions: Type of seizure: _____
 Medications: Diastat Klonopin Versed Medication taken at home Other _____
 Sickie Cell: Anemia Trait

YES NO
 Shunt VP shunt Please explain: _____
 Spina Bifida: YES NO
 Special Diet Please explain: _____
 Vision Problems: Wears glasses Wears contacts Other
 Other Medical Conditions: Please include any medications taken at home only.

Required Signatures

Signature of parent(s) or guardian: _____ Date: _____
 Signature of school nurse: _____ Date: _____