## PART I - HEALTH ASSESSMENT

**To be completed by parent or guardian**

| Student's Full Name | Birthdate (mo,day,yr) | Sex M/F | Name of School | Grade |
|---|---|---|---|---|
| | | | | |

Full Address: (please write on above line) Phone No#

Parent/Guardian Names:

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

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

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

**ASSESSMENT OF STUDENT HEALTH**

**To the best of your knowledge has your child any problems with the following? Please Check**

| | YES | NO | Comments |
|---|---|---|---|
| **Allergies (food, insects, drugs, latex)** | | | |
| **Allergies (seasonal)** | | | |
| **Asthma or Breathing Problems** | | | |
| **Behavior or Emotional Problems** | | | |
| **Birth Defects** | | | |
| **Bleeding Problems** | | | |
| **Cerebral Palsy** | | | |
| **Dental** | | | |
| **Diabetes** | | | |
| **Ear Problems or Deafness** | | | |
| **Eye and Vision Problems** | | | |
| **Head Injury** | | | |
| **Heart Problems** | | | |
| **Hospitalizations (when, where)** | | | |

| | | | |
|---|---|---|---|
| **Lead Poisoning/Exposure** | | | |
| **Learning Problems/Disabilities** | | | |
| **Limits on Physical Activities** | | | |
| **Meningitis** | | | |
| **Prematurity** | | | |
| **Problems with Bladder** | | | |
| **Problems with Bowels** | | | |
| **Problem with Coughing** | | | |
| **Seizures** | | | |
| **Serious Allergic Reactions** | | | |
| **Sickle Cell Disease** | | | |
| **Speech Problems** | | | |
| **Surgery** | | | |
| **Other** | | | |

**Does your child take any medications?**

**No** **Yes** **Name(s)**_____

**Is your child on any special treatments? (nebulizer, epi-pen, etc.)**

**No** **Yes** **Treatment**_____

**Does your child require any special procedures? (catheterization, etc.)**

**No** **Yes**

**Parent/Guardian Signature**_____**Date**_____

## 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.)

_____

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

_____