

PART 1 – HEALTH ASSESSMENT
To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month			Year	
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
ASSESSMENT OF STUDENT HEALTH To the best of your knowledge has your child had any problem 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 or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication?				
No Yes Name of Medications: _____				
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 11 – SCHOOL HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	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 problem, 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 on 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/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.)				

4. RECORD OF IMMUNIZATIONS – 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 yes, 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	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART 11 – 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 for full school participation

_____ problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)

Phone No.

Physician/Nurse Practitioner Signature

Date