PART 1 HEALTH ASSESSMENT

To be completed by parent/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
Anaphylaxis			
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
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(s) 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 II 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

   Specify _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, severe allergic reaction/ anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with the school nurse to develop an emergency plan". ☐ No ☐ Yes

   Specify _____

3. Are there any abnormal findings on evaluation for concern? ☐ No ☐ Yes

   Specify _____

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/health concerns.)

4. **RECORD OF IMMUNIZATIONS**: DHMH 896 is required to be completed by a 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** Tuberculin Test	**Results**	**Date Taken**
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 or full school participation ☐ Problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date