

### ALABAMA STATE DEPARTMENT OF EDUCATION



#### HEALTH ASSESSMENT RECORD

To Parent or Guardian:

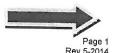
The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

#### This information will be kept confidential. PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)		Birth Dat	е	Sex	School	
Address (Street)						
Home Telephone Number: Cell Pho	Additional Phone	Number:	Grade		Teacher/Homeroom	
Name of Parent/Guardian (Last, First Mid	dle)					Work Phone Number:
Transportation	The second of th					
☐ Bus Rider Bus Number: ☐	Car Rider	☐ Specia	al Needs Bu	ıs		☐ After School
	Part I	- Health Inform				
Place your child receives health care:  Physician's Name:  Address:  Phone:  Community Health Center  Health Department  Hospital Clinic  No Regular Place  Private Doctor /HMO  Preferred Hospital:			Place your child receives dental care:  Dentist's Name:  Address:  Phone:  Community Health Center  Health Department  Hospital Clinic  No Regular Place  Private Dentist /HMO			
Part II – Medical History Catheter Gastric Tube	story Medica	I <b>l Equipment /F</b>	Procedui Oxygen S	res Re	quire	
Vagal Nerve Stimulator (VNS)			□ Wal		GIIL	□ Tracheostomy
Other <i>Please explain:</i>						*
Medications and Procedures at Sch	ool require a P	rescriber/Parent /	uthorizat	ion For	n lan	1: 1: 1: 1

Please Complete Back of Form (Signature Required)

procedure) Please see your school nurse.





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-						
		School Year:				
	Part III – Medica					
□ YES □ NO	KNOWN HEALTH PROBLEMS	al History				
. Lo   NO	If NO, go directly to the bottom of the page and provide parent/guardian signature					
	If YES, and diagnosed by a physician, answer e	ach question below				
□ YES □ NO	Attention Deficit Disorder (ADD)	acti question below,				
D YES D NO	Attention Deficit Hyperactivity Disorder (ADHD)					
	Requires medication					
□ YES □ NO	Allergies:	_ I I				
in in the same in the	□ Food	□ Hives/rash □ Medications				
	□ Insects	□ Breathing difficulty □ Epi-pen				
	□ Environmental	□ Breathing difficulty □ Epi-pen				
	□ Medications	□ Other:				
□ YES □ NO	Asthma Uses an inhaler at school	□ Uses an inhaler at home				
□ YES □ NO	DI VOI III					
- TES - NO	Blood/Bleeding Problems: □Hemophilia,	□Von Willebrand's, □Other				
	Requires medication Please explain:					
□ YES □ NO	Frequent Nose Bleeds: Please explain					
□ YES □ NO	Cancer/Leukemia: Please explain					
□ YES □ NO	Cerebral Palsy: Please explain					
□ YES □ NO	Cystic Fibrosis: Please explain					
□ YES □ NO	Dental Problems: Please explain:					
□ YES □ NO	Diabetes □ Type 1 Diabetes □ Monitors Blood S	Sugars at school - Dogwies L. II				
	I Mornitorio Biood	Sugars at school □ Requires Insulin at school □ Insulin pump				
	200	□ Glucagon order				
	□ Type 2 Diabetes □ Managed with die	et □ Oral medication				
□ YES □ NO						
PES NO	Emotional/Behavioral/Psychological: Please explain	7.:				
□ YES □ NO	Gastrointestinal/Stomach Problems: Please explain Genetic / Rare Disorders: Please explain:					
□ YES □ NO	Headaches: Please explain:					
□ YES □ NO		Both ears				
	□ Tubes □ Cochlear Implant	Both ears □ Hearing loss □ Hearing aid				
□ YES □ NO	Heart Condition:   Activity restrictions:	□ Medications taken at home:				
	Please explain:					
YES NO	Hypertension (High Blood Pressure): Please explain	Ľ				
YES NO	Juvenile Arthritis/Bone-Joint Problems: Please expl	ain:				
YES NO YES NO	Kidney/ Bladder/ Urinary Problems: Please explain:					
YES INO	The fredition of Arcais blace	□ Surgery □ Family History				
יובט מט	Seizures/Convulsions: Type of seizure:  Medications:   Diastat   Klonopin   Versed					
	Medications: □ Diastat □ Klonopin □ Versed  Please explain:	□ Medication taken at home □ Other				
YES D NO	Sickle Cell:   Anemia   Trait					
YES D NO	Shunt: UP shunt Please explain:					
YES   NO	Spina Bifida:					
YES   NO	Special Diet: Please explain:					
YES - NO	Vision Problems:   Wears glasses   Wears con	tacts □ Other				
YES - NO	Other Medical Conditions: Please include any medical	Cations taken at home only				
		sale to taken at nome only.				
Required Signatures						
ignature of parent(s) or guardian: Date:						
Signatura of ook	al numae.					
Signature of school nurse: Date:						