



**State of Alabama Department of Education
Health Assessment Record
School Year: _____ - _____**



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 strictly confidential.

**To be completed by parent/guardian.
PLEASE PRINT. Return to the School Nurse.**

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(City and Zip code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Home Telephone Number		School	Grade	
Name of Parent/Guardian (Last, First, Middle)				
Transportation				
<input type="checkbox"/> Bus Rider <input type="checkbox"/> Car Rider <input type="checkbox"/> Special Needs Bus <input type="checkbox"/> After School Program				

Part I – Health Information

Place where your child receives regular health care:	Child has:
<input type="checkbox"/> Health Department <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Community Health Center <input type="checkbox"/> Private Doctor/HMO <input type="checkbox"/> Other _____ <input type="checkbox"/> No regular place	<input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance <input type="checkbox"/> ALLKIDS <input type="checkbox"/> Other: _____
Local Physician's Name: _____	Telephone: _____
Address: _____	

Authorizations:

- I authorize the school nurse, the registered nurse (RN) or licensed practical nurse (LPN), to talk with the physician(s) should a question come up about my child's medical conditions.**
- I do NOT authorize the school nurse, the RN or LPN, to talk with the physician(s) should a question come up about my child's medical conditions.**
- I authorize for my child to participate in all school health screenings.**
- I authorize the release of my child's communicable disease information (chicken pox cases, etc...) to be released to the local Public Health Department.**

FOR OFFICE USE ONLY			
Acuity Scale:			
Level A Nursing Dependent	Level B Medically Fragile	Level C Medically Complex	Level D Health Concerns

Part II – Medical History



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➤➤➤➤➤ Check only those that apply. <<<<<<<

<input type="checkbox"/> NO KNOWN HEALTH PROBLEMS. Please go directly to the bottom of the page and provide parent/guardian signature.	
<input type="checkbox"/> Attention Deficit Disorder (ADD) OR Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Requires medication? <input type="checkbox"/> To be given while at school?
<input type="checkbox"/> Asthma:	<input type="checkbox"/> He/She uses an inhaler at school? <input type="checkbox"/> He/She uses an inhaler at home?
<input type="checkbox"/> Allergies: (severe) <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Environmental <input type="checkbox"/> Medications	<input type="checkbox"/> Hives/rash? <input type="checkbox"/> Breathing difficulty? <input type="checkbox"/> Epi-pen?
<input type="checkbox"/> Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)	<input type="checkbox"/> Requires medication? Please explain:
<input type="checkbox"/> Cancer/Leukemia:	Please explain:
<input type="checkbox"/> Cerebral Palsy:	Please explain:
<input type="checkbox"/> Cystic Fibrosis:	Please explain:
<input type="checkbox"/> Dental Problems:	Please explain:
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 Diabetic <input type="checkbox"/> Type 2 Diabetic	<input type="checkbox"/> Monitors Blood Sugars while at school? <input type="checkbox"/> Requires Insulin at school? <input type="checkbox"/> Glucagon order? <input type="checkbox"/> Insulin pump? <input type="checkbox"/> Managed with diet?
<input type="checkbox"/> Emotional/Behavioral/Psychological: Please explain:	
<input type="checkbox"/> Genetic Disorder: Please explain:	
<input type="checkbox"/> Headaches: Please explain:	
<input type="checkbox"/> Hearing Problems:	<input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Hearing loss? <input type="checkbox"/> Hearing aid? <input type="checkbox"/> Cochlear Implant
<input type="checkbox"/> Heart Condition: Please explain: Are there any activity restrictions? Any medications taken at home only?	
<input type="checkbox"/> Hypertension (High Blood Pressure):	
<input type="checkbox"/> Juvenile Arthritis/Bone-Joint Problems: Please explain:	
<input type="checkbox"/> Kidney Problems: Please explain:	
<input type="checkbox"/> Scoliosis:	<input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery
<input type="checkbox"/> Seizures/Convulsions: Please explain:	Type of seizure: _____ <input type="checkbox"/> Diastat order
<input type="checkbox"/> Sickle Cell Anemia:	
<input type="checkbox"/> Spina Bifida:	
<input type="checkbox"/> Special Diet: Please explain:	
<input type="checkbox"/> Vision Problems:	<input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other, _____
<input type="checkbox"/> Other Medical Conditions: Please include <u>any</u> medications taken at home only.	

Part III – Medical Equipment /Procedures Required

<input type="checkbox"/> Gastric Tube	<input type="checkbox"/> Nebulizer Treatments	<input type="checkbox"/> Oxygen Supplement	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Vagal Nerve Stimulator	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker

Required Signatures

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