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 _____

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
Head			
Eyes			
ENT			
Dental			
Respiratory			
Cardiac			
GI			
GU			
Musculoskeletal/orthopedic			
Neurological			
Skin			
Endocrine			
Psychosocial			

Health Area of Concern	YES	NO
Attention Deficit/Hyperactivity		
Behavior/Adjustment		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Mobility		
Nutrition		
Physical Illness/Impairment		
Psychosocial		
Speech/Language		
Vision		
Other		

REMARKS: (Please explain any abnormal findings.)

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	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART I - 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 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(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 - continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has

9 no evident problem that may affect learning or full school participation ☐ problems noted above

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Additional Comments:

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