2024-2025

Health Assessment Form

Staff Use | Admin: __________

Head of School: __________

Teacher:__________

To be completed by Legal Guardian:

Student Full Legal Name: ____

Birthdate (MM/DD/YYYY): _______/________/____________ Parent Phone: (________)_______-____________

Home Address: ____

City: ____ State: __________ Zip Code: _________________

Parent/Guardian Name: ____

Relationship to Student: _________________________________ Grade Entering Into: _____________________

Health Concerns to be shared with authorized persons (*school administrators, teachers, and other school personnel who require such information to perform their assigned duties*):____

____

____

____

To be completed by Health Care Provider:

Medication(s) prescribed for student: ____

____

____

Student's allergies, type, and response required: ____

____

____

Special diet instructions: ____

____

____

Health-related recommendations to enhance the student's school performance: _________________________

____

____

Passed vision screening? YES or NO

Concerns related to student's vision: ____

____

____

Passed hearing screening? YES or NO

Concerns related to student's hearing: ____

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____

Medical Provider comments: ____

____

____

____

____

Please attach other applicable school health forms:

- ❏ School medication authorization form attached
- ❏ Diabetes care plan attached
- ❏ Asthma action plan attached
- ❏ Health care plans for other conditions attached
- ❏ Immunization Records attached

Health Care Professional's Certification

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Signature: ____ Date of Exam: _______/_______/_________

Name: ____ Title: ______________________________

Practice/Clinic Name: ____

Practice/Clinic Address: ____

Practice/Clinic City: ______________________________________ State: _________ Zip Code: _____________

Phone Number: (________)________-__________ Email: ____

Provider Stamp Here:

Rev. 1/24