



ALABAMA STATE DEPARTMENT OF EDUCATION



HEALTHASSESSMENT 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 confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School
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Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom
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Name of Parent/Guardian (Last, First Middle)	Work Phone Number:
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Transportation

Bus Rider Bus Number:       Car Rider       Special Needs Bus       After School

Part I- Health Information

Place your child receives health care: Physician's Name: _____ Address: _____ Phone: _____ <input type="checkbox"/> Community Health Center <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> No Regular Place <input type="checkbox"/> Private Doctor /HMO	Your child's Insurance Information: <input type="checkbox"/> ALL KIDS <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Private Insurance	Place your child receives dental care: Dentist's Name: _____ Address: _____ Phone: _____ <input type="checkbox"/> Community Health Center <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> No Regular Place <input type="checkbox"/> Private Dentist/HMO
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Preferred Hospital: \_\_\_\_\_

Part II- Medical History Medical Equipment /Procedures Required at School

Catheter     Gastric Tube     Nebulizer Treatments     Oxygen Supplement     Tracheostomy

Vagal Nerve Stimulator (VNS)     Ventilator     Wheelchair     Walker

Other Please explain:

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)





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Part III - Medical History

<input type="checkbox"/> YES <input type="checkbox"/> NO	<p><b>KNOWN HEALTH PROBLEMS</b>          If NO, go directly to the bottom of the page and provide parent/guardian signature          If YES, and diagnosed by a physician, answer each question below.</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Disorder (ADD)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Hyperactivity Disorder (ADHD)
	Requires medication <input type="checkbox"/> At school <input type="checkbox"/> At Home
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Allergies: <input type="checkbox"/> Food _____ <input type="checkbox"/> Hives/rash <input type="checkbox"/> Medications</p> <p><input type="checkbox"/> Insects _____ <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Epi-pen</p> <p><input type="checkbox"/> Environmental</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Asthma <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Blood/Bleeding Problems: <input type="checkbox"/> Hemophilia, <input type="checkbox"/> Von Willebrand's, <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Requires medication <i>Please explain:</i></p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Nose Bleeds: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Leukemia: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cystic Fibrosis: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at school <input type="checkbox"/> Requires Insulin at school</p> <p><input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Managed with diet <input type="checkbox"/> Insulin pump</p> <p><input type="checkbox"/> Oral medication</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional/Behavioral/Psychological: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Genetic / Rare Disorders: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>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</p> <p><input type="checkbox"/> Tubes <input type="checkbox"/> Cochlear Implant</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Heart Condition: <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home:</p> <p><i>Please explain:</i></p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension (High Blood Pressure): <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/ Bladder/ Urinary Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Scoliosis: <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Seizures/Convulsions: Type of seizure: _____</p> <p>Medications: <input type="checkbox"/> Diastat <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____</p> <p><i>Please explain:</i></p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell: <input type="checkbox"/> Anemia <input type="checkbox"/> Trait
<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt: <input type="checkbox"/> VP shunt <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida:
<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Vision Problems: <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other</p>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions: <i>Please include <b>any</b> medications taken at home only.</i>

**Required Signatures**

Signature of parent(s) or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of school nurse: \_\_\_\_\_ Date: \_\_\_\_\_