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)		Birth Date	Sex

Address (Street)	Race/Ethnicity	
	☐ American Indian	☐ White, not of Hispanic origin
(City and Zip code)	☐ Asian	☐ Hispanic/Latino
	☐ Black, not of Hispanic origin	☐ Other

Home Telephone Number	Cell Telephone Number	School	Grade

Name of Parent/Guardian (Last, First, Middle)

Transportation

☐ Bus Rider ☐ Car Rider ☐ Special Needs Bus ☐ After School Program

Part I – Health Information

Place where your child receives regular health care:

☐ Health Department
☐ Hospital Clinic
☐ Community Health Center
☐ Private Doctor/HMO
☐ Other _____
☐ No regular place

Physician's Name:_____

Address: _____

_____

Tel: _____

Place where your child receives regular dental care:

☐ Health Department
☐ Hospital Clinic
☐ Community Health Center
☐ Private Doctor/HMO
☐ Other _____
☐ No regular place

Dentist's Name: _____

Address: _____

_____

Tel: _____

Type of Insurance your child has:

☐ Medicaid
☐ No Insurance
☐ Private Insurance
☐ ALLKIDS
☐ Other:
_____

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, such as vision, hearing and scoliosis.**

☐ **I authorize the yearly review of my child's Certificate of Immunization (Blue Slip) by 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

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Part II – Medical History

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

Part III – Medical Equipment /Procedures Required at School

□ Catheter □ Gastric Tube □ Nebulizer Treatments □ Oxygen Supplement □ Tracheostomy
□ Vagal Nerve Stimulator (VNS) □ Ventilator □ Wheelchair □ Walker

Required Signatures

Signature of parent(s) or guardian:_____ **Date:**_____

Signature of school nurse: _____ **Date:**_____