January 2016

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PADRES DEBEN COMPLETAR ESTA SECCION

Nombre de Estudiante: ☐ M ☐ F

(Apellido) (Primer) (Segundo)

Fecha de Nacimiento (M/D/año): **Nombre de Escuela:**

Origen Hispano o Latino: ☐ 1 Si ☐ 2 No

Raza: ☐ 1 Otra No-Blanco ☐ 2 Blanco ☐ 3 Negro ☐ 4 Indio Americano ☐ 5 Chino ☐ 6 Japonés ☐ 7 Hawaiano ☐ 8 Filipino ☐ 9 Otro Asiático ☐ 10 Desconocido

Dirección de Casa: **Ciudad:** **Estado:** **Condado:**

Información de Padres: Nombre del Padre, Tutor, o persona en el lugar de los padres:

Teléfono(s)

Casa:

Trabajo:

Cellular:

Preocupaciones de salud para ser compartidas con las personas autorizadas (administradores de la escuela , maestros y otro personal escolar que requieren de dicha información para desempeñar sus tareas asignadas):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

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

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

Height: _____ Hgb/Hct: _____ Date Tested _____

Weight: _____ Lead: _____ Date Tested _____

BP: _____

Public Health
HEALTH AND HUMAN SERVICES

January 2016

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions 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.

Name: Title:

Signature:_____ Date (m/d/yyyy):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here: