ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: 2023 - 2024

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

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle)	Work Phone Number:

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:_____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Doctor /HMO**

Your child's Insurance Information:

☐ **ALL KIDS**

☐ **Medicaid**

☐ **No Insurance**

☐ **Other** _____

☐ **Private Insurance**

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone:_____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Dentist /HMO**

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

□ YES □ NO	**KNOWN HEALTH PROBLEMS** 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.
□ **YES** □ **NO** □ **YES** □ **NO**	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication □ At school □ At Home
□ **YES** □ **NO**	**Allergies:** □ **Food** _____ □ Hives/rash □ Medications □ **Insects** _____ □ Breathing difficulty □ Epi-pen □ **Environmental** _____ □ **Medications** _____ □ Other:
□ **YES** □ **NO**	**Asthma** □ Uses an inhaler at school □ Uses an inhaler at home
□ **YES** □ **NO**	**Blood/Bleeding Problems:** □**Hemophilia,** □**Von Willebrand's,** □**Other** □ **Requires medication** ***Please explain:***
□ **YES** □ **NO**	**Frequent Nose Bleeds:** *Please explain*
□ **YES** □ **NO**	**Cancer/Leukemia:** *Please explain*
□ **YES** □ **NO**	**Cerebral Palsy:** *Please explain*
□ **YES** □ **NO**	**Cystic Fibrosis:** *Please explain*
□ **YES** □ **NO**	**Dental Problems:** *Please explain:*
□ **YES** □ **NO**	**Diabetes** □ **Type 1 Diabetes** □ Monitors Blood Sugars at school □ Requires Insulin at school □ Insulin pump □ Glucagon order □ **Type 2 Diabetes** □ Managed with diet □ Oral medication
□ **YES** □ **NO**	**Emotional/Behavioral/Psychological:** *Please explain:*
□ **YES** □ **NO**	**Gastrointestinal/Stomach Problems:** *Please explain:*
□ **YES** □ **NO**	**Genetic / Rare Disorders:** *Please explain:*
□ **YES** □ **NO**	**Headaches:** *Please explain:*
□ **YES** □ **NO**	**Hearing Problems:** □ Right Ear □ Left Ear □ Both ears □ Hearing loss □ Hearing aid □ Tubes □ Cochlear Implant
□ **YES** □ **NO**	**Heart Condition:** □ ***Activity restrictions****:* □ **Medications taken at home***:* *Please explain:*
□ **YES** □ **NO**	**Hypertension (High Blood Pressure):** *Please explain:*
□ **YES** □ **NO**	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
□ **YES** □ **NO**	**Kidney/ Bladder/ Urinary Problems:** *Please explain:*
□ **YES** □ **NO**	**Scoliosis:** □ No Treatment □ Wears Brace □ Surgery □ Family History
□ **YES** □ **NO**	**Seizures/Convulsions:** Type of seizure: _____ *Medications:* □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other _____ *Please explain:*
□ **YES** □ **NO**	**Sickle Cell:** □ Anemia □ **Trait**
□ **YES** □ **NO**	**Shunt:** □ VP shunt *Please explain:*
□ **YES** □ **NO**	**Spina Bifida:**
□ **YES** □ **NO**	**Special Diet:** *Please explain:*
□ **YES** □ **NO**	**Vision Problems:** □ Wears glasses □ Wears contacts □ Other
□ **YES** □ **NO**	**Other Medical Conditions:** *Please include **any** medications taken at home only.*

Required Signatures

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

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

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