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

January 2016

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)

PARENT to COMPLETE THIS SECTION

Student Name: ☐ M ☐ F

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

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

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:

Public Health
HEALTH AND HUMAN SERVICES

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:

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FORMULARIO DE EVALUACION DE SALUD Y TRANSMISION DE CAROLINA DEL NORTE

Este formulario y la información en este formulario serán archivados en la escuela a la que asistió el estudiante y es confidencial y no un registro público.
(Aprobado por el Departamento de Instrucción Pública de Carolina del Norte y el Departamento de Salud y Servicios Humanos)

LOS PADRES DEBEN COMPLETAR ESTA SECCION

Nombre del Estudiante: ☐M ☐F

(Apellido) (Primer Nombre) (Segundo nombre)

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

Hispano /Latino: ☐1 Si ☐2 No

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

Dirección: **Ciudad:** **Estado:** **Condado**

Información del Padre: Nombre del Padre, Apoderado, u otra persona en lugar de los padres:

Teléfono (s)
Casa:
Trabajo:
Teléfono
Celular:

Las condiciones de salud para ser compartidas con las personas autorizadas (administradores de la escuela, maestros, y otro personal escolar que requiera dicha información para realizar 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:

Public Health
HEALTH AND HUMAN SERVICES

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: ☐

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Name: Title:

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

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

Provider Stamp Here:

Public Health
HEALTH AND HUMAN SERVICES