January 2016rev

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)

**PARENT to COMPLETE THIS SECTION**

**Student Name**:

(Last) (First) (Middle)

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

**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:



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**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):

Date of Exam (if Different):

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

Provider Stamp Here: