



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)

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):

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:





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:

