



**PART II - SCHOOL HEALTH ASSESSMENT**  
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
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1. Does the child have a diagnosed medical condition?  
No Yes \_\_\_\_\_  
\_\_\_\_\_

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school?  
(e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes,  
please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".  
No Yes \_\_\_\_\_  
\_\_\_\_\_

3. Are there any abnormal findings on evaluation for concern?  
  
Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.  
No Yes - \_\_\_\_\_  
**(A medication administration form must be completed for medication administration in school).**

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.  
No Yes \_\_\_\_\_

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

**PART II - SCHOOL HEALTH ASSESSMENT - continued**

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(Child's Name) \_\_\_\_\_ has had a complete physical examination and has

9 no evident problem that may affect learning or full school participation          problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)

Phone No.

Physician/Nurse Practitioner Signature

Date