



**State of Alabama Department of Education
Health Assessment Record
School Year: _____ - _____**



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 strictly confidential.

**To be completed by parent/guardian.
PLEASE PRINT. Return to the School Nurse.**

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity <input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
(City and Zip code)				
Home Telephone Number		School		Grade
Name of Parent/Guardian (Last, First, Middle)				
Transportation <input type="checkbox"/> Bus Rider <input type="checkbox"/> Car Rider <input type="checkbox"/> Special Needs Bus <input type="checkbox"/> After School Program				

Part I – Health Information

Place where your child receives regular health care:

Child has:

- ☐ Health Department
- ☐ Hospital Clinic
- ☐ Community Health Center
- ☐ Private Doctor/HMO
- ☐ Other _____
- ☐ No regular place

- ☐ Medicaid
- ☐ No Insurance
- ☐ Private Insurance
- ☐ ALLKIDS
- ☐ Other: _____

Local Physician's Name: _____ **Telephone:** _____

Address: _____

Authorizations:

- ☐ I authorize the school nurse, the registered nurse (RN) or licensed practical nurse (LPN), to talk with the physician(s) should a question come up about my child's medical conditions.
- ☐ I do NOT authorize the school nurse, the RN or LPN, to talk with the physician(s) should a question come up about my child's medical conditions.
- ☐ I authorize for my child to participate in all school health screenings.
- ☐ I authorize the release of my child's communicable disease information (chicken pox cases, etc...) to be released to the local Public Health Department.

FOR OFFICE USE ONLY Acuity Scale:			
Level A Nursing Dependent	Level B Medically Fragile	Level C Medically Complex	Level D Health Concerns

Part II – Medical History