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

➢➢➢➢➢➢Check only those that apply. ➣➣➣➣➣➣	
□ **NO KNOWN HEALTH PROBLEMS. Please go directly to the bottom of the page and provide parent/guardian signature.**	
□ **Attention Deficit Disorder (ADD) OR Attention Deficit Hyperactivity Disorder (ADHD)**	□ Requires medication? □ To be given while at school?
□ **Asthma:**	□ He/She uses an inhaler at school? □ He/She uses an inhaler at home?
□ **Allergies: (severe)** □ **Food** □ **Insects** □ **Environmental** □ **Medications**	□ Hives/rash? □ Breathing difficulty? □ Epi-pen?
□ **Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)**	□ Requires medication? Please explain:
□ **Cancer/Leukemia:**	Please explain:
□ **Cerebral Palsy:**	Please explain:
□ **Cystic Fibrosis:**	Please explain:
□ **Dental Problems:**	Please explain:
□ **Diabetes:** □ **Type 1 Diabetic** □ **Type 2 Diabetic**	□ Monitors Blood Sugars while at school? □ Requires Insulin at school? □ Glucagon order? □ Insulin pump? □ Managed with diet?
□ **Emotional/Behavioral/Psychological:** *Please explain:*	
□ **Genetic Disorder:** *Please explain:*	
□ **Headaches:** *Please explain:*	
□ **Hearing Problems:**	□ Right Ear □ Left Ear □ Both ears □ Hearing loss? □ Hearing aid? □ Cochlear Implant
□ **Heart Condition:** *Please explain: Are there any activity restrictions? Any medications taken at home only?*	
□ **Hypertension (High Blood Pressure):**	
□ **Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*	
□ **Kidney Problems:** *Please explain:*	
□ **Scoliosis:**	□ No Treatment □ Wears Brace □ Surgery
□ **Seizures/Convulsions:** *Please explain:*	Type of seizure: _____ □ Diastat order
□ **Sickle Cell Anemia:**	
□ **Spina Bifida:**	
□ **Special Diet:** *Please explain:*	
□ **Vision Problems:**	□ Wears glasses □ Wears contacts □ Other, _____
□ **Other Medical Conditions:** *Please include **any** medications taken at home only.*	

Part III – Medical Equipment /Procedures Required

□ Gastric Tube □ Nebulizer Treatments □ Oxygen Supplement □ Tracheostomy
□ Vagus Nerve Stimulator □ Ventilator □ Wheelchair □ Walker

Required Signatures

Signature of parent(s) or guardian: _____ **Date:** _____

Signature of school nurse: _____ **Date:** _____