ALABAMA STATE 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 confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle) — Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone: _____

- ☐ **Community Health Center**
- ☐ **Health Department**
- ☐ **Hospital Clinic**
- ☐ **No Regular Place**
- ☐ **Private Doctor /HMO**

Your child's Insurance Information:

- ☐ **ALL KIDS**
- ☐ **Medicaid**
- ☐ **No Insurance**
- ☐ **Other** _____
- ☐ **Private Insurance**

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone: _____

- ☐ **Community Health Center**
- ☐ **Health Department**
- ☐ **Hospital Clinic**
- ☐ **No Regular Place**
- ☐ **Private Dentist /HMO**

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)