NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM January 2016rev 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) PARENT to COMPLETE THIS SECTION Student Name: (Middle) (First) School Name: Birthdate (M/D/WWY): County: State: City: Home Address: Telephone(s) Parent Information: Name of Parent, Guardian, or person standing in loco parentis: 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): HEALTH CARE PROVIDER TO COMPLETE

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:



iblic Health

learing screening information	□ No				
learing screening information assed hearing screening: [] Yes   oncerns related to student's heari	ng:				
OUCELLE JEIGGE CE			. C-1/010/41/D		Rind Humology (2)
ecommendations, concerns, o	- 1 de chide	nt's health and re	quired school tollow-up.		
ecommendations, concerns, o	r needs related to stade				
chool follow-up needed: 🗌 Ye	s 🗆 No				
		130 - 31			
ledical Provider Comments:					
		•			
lease attach other applicable :	school health forms:				
A Markada					
nmunization record attached: chool medication authorization for	m attached:				
	H				
iabetes care plan attached: sthma action plan attached: ealth care plans for other conditio	ns attached:				
-tore for other condido	IIS aumorious				
ealth care plans to our		ith assessment in a	ccordance with G.S. 130A-	140(b) that included a medulosis. I certify that the in	lical history and formation on this
lealth Care Professional's Cert	ification udent named above, a hea	ith assessment in a d if appropriate, tes	ccordance with G.S. 130A- sting for anemia and tubero Title:	140(b) that included a medulosis. I certify that the in	lical history and formation on this
lealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, tes		140(b) that included a medulosis. I certify that the in	lical history and formation on this
eaith Care Professional's Cert certify that I performed, on the st hysical examination with screening from is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, ter	Title:	•	lical history and formation on this
tealth Care Professional's Cert certify that I performed, on the st hysical examination with screening form is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Tide: Date (n	· •{d{yyyy <b>):</b>	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the ame:	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Title:  Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
tealth Care Professional's Certify that I performed, on the st hysical examination with screening from is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, te	Title:  Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
lealth Care Professional's Cert lealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the dame:	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Tide: Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Title:  Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Title:  Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to the	ification udent named above, a hea	ith assessment in a	Title:  Date (n	n/d/yyyy): Exam (if Different):	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening from is accurate and complete to the	ification udent named above, a hea	ith assessment in a	Title:  Date (n  Date of  Practice/Clinic Addres	n/d/yyyy): Exam (if Different):	lical history and formation on this
lealth Care Professional's Cert certify that I performed, on the st hysical examination with screening form is accurate and complete to the	ification  udent named above, a hea g for vision and hearing, an ne best of my knowledge.		Title:  Date (n	n/d/yyyy): Exam (if Different): s:	lical history and formation on this
lealth Care Professional's Cert certify that I performed, on the st hysical examination with screening orm is accurate and complete to th lame: lignature: ractice/Clinic Name:	ification udent named above, a hea	ith assessment in a d if appropriate, tes	Title:  Date (n  Date of  Practice/Clinic Addres	n/d/yyyy): Exam (if Different): s:	lical history and formation on this
lealth Care Professional's Cert certify that I performed, on the st hysical examination with screening form is accurate and complete to the	ification  udent named above, a hea g for vision and hearing, an ne best of my knowledge.		Title:  Date (n  Date of  Practice/Clinic Addres	n/d/yyyy): Exam (if Different): s:	lical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening irm is accurate and complete to th ame: ignature: ractice/Clinic Name:	ification  udent named above, a hea g for vision and hearing, an ne best of my knowledge.		Title:  Date (n  Date of  Practice/Clinic Addres	n/d/yyyy): Exam (if Different): s:	tical history and formation on this
ealth Care Professional's Cert certify that I performed, on the st hysical examination with screening irm is accurate and complete to th ame: ignature: ractice/Clinic Name:	ification  udent named above, a hea g for vision and hearing, an ne best of my knowledge.		Title:  Date (n  Date of  Practice/Clinic Addres	n/d/yyyy): Exam (if Different): s:	tical history and formation on this



Public Ficalds