Christ's Little Acorns

Health Assessment Form 2017-2018

1300 North University Parkway, High Point, NC 27262
Phone: 336-889-6169 • Fax: 336-889-6528

Personal Data *(TO BE COMPLETED BY PARENT OR GUARDIAN)*

Child's Name: _____ _____ _____
Last First Middle

Birthdate: _____/_____/_____ Age: _____ Sex: □ Male □ Female
Month Day Year

Please list any health problems that might affect your child's performance in school: _____

_____

Illnesses or Developmental Problems (Please check any of the following that the child has):

- □ Asthma
- □ Bleeding Problems
- □ Bone/Muscle Problems
- □ Bowel Problems
- □ Cancer/Leukemia
- □ Attention/Learning
- □ Convulsions/Seizures
- □ Cystic Fibrosis
- □ Cerebral Palsy
- □ Dental Problems
- □ Diabetes
- □ Emotional/Behavioral
- □ Ear Infections
- □ Heart Problems
- □ Hearing Problems
- □ Meningitis
- □ Sickle Cell Anemia
- □ Vision Problems
- □ Skin Problems
- □ Speech Problems
- □ Stomach Aches
- □ Urinary/Bladder
- □ Other_____
- □ NONE

Health Assessment *(TO BE COMPLETED BY HEALTHCARE PROVIDER)*

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the State standards for Health Check Services

Immunizations

Attach a copy of the child's current immunization record.

Exemptions

NC State Immunization Law require that a statement must be on file at school in student's permanent record. (www.NVIC.org)

Attach a copy of your exemption form

Date of Assessment: _____/_____/_____

Please provide additional information about illnesses or developmental problems. Also, provide information about any other important health conditions. _____

_____

_____

In your opinion, will any of the above illnesses or conditions affect the child's performance in school? If so, specify:_____

_____

_____

List any allergies that the child has (e.g. food, insect stings, medicine, etc.):_____

What type of allergic reaction occurs?_____

Is medication required? □ No □ Yes If yes, medication and dosage: _____

Does this child take medication on a regular basis (other than above)? □ No □ Yes

If yes, list medication, purpose of medication, dose and possible side effects: _____

Signature of Health Care Provider _____ Date _____

Address: _____ Phone: _____