

# PART 1 - HEALTH ASSESSMENT

(To be completed by parent/guardian)

## THE HARBOR SCHOOL

Student Name (Last, First, Middle)	Birth Date	School Name	Grade
Address (Street, City, State, Zip)			Home Phone
Parent Guardian		Parent Guardian	
Physician/Nurse Practitioner Name and Address (Street, City, State, Zip)			
Dentist Name and Address (Street, City, State, Zip)			
Other source(s) from which the student receives health care. (If none, write "None.")			

### ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know? Place an "X" for "Yes," or "No" for each of the following:

	Yes	No	Comments
Allergies (Drugs, Food, Insects)			
Asthma			
Behavior or Emotional Problem			
Birth Defects			
Bladder Problem			
Bleeding Problems			
Bowel Problems			
Cerebral Palsy			
Concussion (Head Injury)			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning			
Limits on Activity			
Medication			
Meningitis			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech Problem			
Surgery			

I give my permission for confidential and discreet use of Part 2, the health evaluation completed by the physician/nurse practitioner, to meet my child's health and educational needs in school. (Check one)  Yes  No

**Signature, Parent/Guardian**

**Date**

**IMPORTANT:** Schedule an appointment for a medical examination of your child; share the above information with the physician or nurse practitioner, have him/her complete Part 2 after the examination and then return the form to the school.

## PART 2 - HEALTH EVALUATION

(Parents: Please print this form and have completed by a physician/nurse practitioner)

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school (e.g., seizures, asthma, insect sting allergy, bleeding problem, diabetes, heart problem)? If "Yes", please describe.

No  Yes \_\_\_\_\_

2. Is this child on long-term technology assistance?  No  Yes \_\_\_\_\_

3. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a check () in the appropriate box.

### CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical/Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain all yes answers. Include recommendations for referral and treatment.

4. Immunizations given on this visit:  DPT/Td # \_\_\_\_\_;  Polio # \_\_\_\_\_;  MMR # \_\_\_\_\_;  Other \_\_\_\_\_

5. Tuberculin Test: Results  Positive  Negative \_\_\_\_\_  
Type      Date (most recent)      Height      Weight      BP      Pulse Rate      Date Taken

6. Is the student on long-term medication? If yes, please describe.

No  Yes \_\_\_\_\_  
 (a Medication Form/Physician's Order must *be* completed for in-school administration for all OTC and prescribed medications)

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

No  Yes \_\_\_\_\_

8. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed below that are **NOT CROSSED OUT?**

No  Yes  Not Applicable

Baseball	Football	Pompons	Track/Field
Basketball	Golf	Soccer	Volleyball
Cheerleading	Gymnastics	Softball	Wrestling (minimum weight)
Cross Country	Indoor Track	Swimming/Diving	Other (specify) _____
Field Hockey	Lacrosse	Tennis	

If you would like to discuss this student's health with school or school health personnel, check title below

Nurse assigned to school  Teacher  Counselor  Principal

Student Name (Type/print) \_\_\_\_\_ has had a complete history and physical examination at our office and has no evident health problem except as noted above.

\_\_\_\_\_  
 Physician/Nurse Practitioner (Print)      Phone Number      Original Signature, Physician/Nurse Practitioner      Date

**IMPORTANT: Maryland Immunization Certification is required by law. Please complete Form DHMH 896.**