January 2016

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

FORMULARIO DE EVALUACION DE SALUD Y TRANSMISION DE CAROLINA DEL NORTE

Este formulario y la información en este formulario serán archivados en la escuela a la que asistió el estudiante y es confidencial y no un registro público.
(Aprobado por el Departamento de Instrucción Pública de Carolina del Norte y el Departamento de Salud y Servicios Humanos)

LOS PADRES DEBEN COMPLETAR ESTA SECCION

Nombre del Estudiante:

(Apellido) (Primer Nombre) (Segundo nombre)

Fecha de Nacimiento (M/D/YYYY): **Nombre de la Escuela:**

Dirección: **Ciudad:** **Estado:** **Condado**

Información del Padre: Nombre del Padre, Apoderado, u otra persona en lugar de los padres:

Teléfono (s)
Casa:
Trabajo:
Teléfono
Celular:

Las condiciones de salud para ser compartidas con las personas autorizadas (administradores de la escuela, maestros, y otro personal escolar que requiera dicha información para realizar sus tareas asignadas):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

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:

Public Health
HEALTH AND HUMAN SERVICES

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature:_____ Date (m/d/yyyy):
Date of Exam (if Different):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here: