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

Januari 2016

FOMU YA NORTH CAROLINA YA UPELEKAJI WA UCHUNGUZI WA AFYA

Fomu hii na maelezo yaliyoko kwenye fomu hii yatadumishwa kwenye faili katika shule ambayo mtoto aliyetajwa hapa atakuwepo na ni ya siri wala si rekodi ya umma.
(Imepitishwa na Idara ya North Carolina ya Mafunzo kwa Umma na Idara ya Afya na Huduma kwa Wanadamu)

MZAZI anapaswa KUJAZA SEHEMU HII

Jina la Mwanafunzi:

(La ukoo) (La kwanza) (La kati)

Tarehe ya Kuzaliwa (Mwezi/Siku/Mwaka): **Jina la Shule:**

Anwani ya Nyumbani: **Jiji:** **Jimbo:** **Kaunti:**

Maelezo kuhusu Mzazi: Jina la Mzazi, Mlezi, au mwakilishi wa mzazi

Simu:

Nyumbani:

Kazini:

Simu ya Mkononi:

Mashaka ya Kiafya yanapaswa kujulishwa kwa (wasimamizi wa shule, waalimu, na wahudumu wengine wa shule wanaohitaji maelezo kama haya ili waweze kutekeleza majukumu yao waliyopewa):

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:

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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:

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