KEYPORT PUBLIC SCHOOLS
HEALTH ASSESSMENT FORM

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

Please print

Name of Student (Last, First, Middle)	Birth Date	Sex
Address (Street)	Home Telephone Number (including area code)	
(Town and Zip Code)	Student's Physician or Primary Health Care Provider	
Parent/Guardian (Last, First, Middle)	Parent/Guardian (Last, First, Middle)	

Part I – To be completed by parent - *Important:* Complete Part I before your child is examined. Take this form with you to the health care provider's office.

Please check yes or no to the following questions (explain all "yes" answers in the space provided below.)

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)?
2.	☐	☐	Does your child have any other specific illness, physical deformity or problem (asthma, diabetes, heart murmur, seizures, etc.)?
3.	☐	☐	Does your child have any restrictions on physical activity?
4.	☐	☐	Does your child have any allergies (food, insects, medication, etc.)?
5.	☐	☐	Does your child take any medication (daily or occasionally)?
6.	☐	☐	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
7.	☐	☐	Has your child had any hospitalization, operation, or major illness (specify problem)?
8.	☐	☐	Has your child had any significant injury or accident (specify problem)?
9.	☐	☐	Are you claiming exemption from immunization guidelines?
10.	☐	☐	Have there been any recent changes in the family (relocation, death, divorce, etc.)?
11.	☐	☐	Would you like to discuss anything about your child's health with the school nurse?

This child is number _____ of _____ children.

(Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.)

_____

_____

_____

_____

_____

_____

I give permission for release of essential information on this form for confidential use in the school for meeting my child's health and educational needs.

_____

Signature of Parent/Guardian

_____

Date

(To be maintained in student's Cumulative School Health Record)

(OVER)

Part II – Medical Evaluation

To the Health Care Provider: Please complete and sign. **Student's Name:**

_____

Screening/Test Results	Immunization Record
Note: *Mandated Screening/Tests/Immunizations	Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school

Under New Jersey State Law

*Height	*Vision			*Auditory	
*Weight	With Glasses	R 20/	L 20/	R	Pass/Fail
*B/P					
Pulse	Without Glasses	R 20/	L 20/	L	

Other Test Results (TB, Sickle Cell, HGB/HCT, Lead, etc.)

Test	Date	Results
Mantoux		

Scoliosis Screening
(Mandatory for ages 10-18)

☐ Normal ☐ Abnormal ☐ Referral

enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	
DTP	*	*	*	*		One dose of any DTP containing vaccine must be given on or after 4th birthday
DTP/Hib						
DtaP						
DT/Td						
OPV						OPV or IPV is acceptable-must be given one dose on or after 4th birthday
IPV	*	*	*			
MMR	*	*		First MMR or individual measles, mumps and rubella vaccines must be given on or after first birthday		
Measles						
Mumps						
Rubella						
HIB				* For students younger than age 5		
HBV	*	*	*	* For students born 1-1-90 or later		
Varicella		Or disease date:				

Other Vaccines (Specify)

Documented laboratory evidence of immunity to:
☐ Measles ☐ Rubella ☐ Mumps ☐ HBV
Must attach lab report to this form.
Medical Exemption ☐ Permanent ☐ Temporary
Reason_____

Reason must be consistent with ACIP or AAP guidelines

_____
_____
Student's Name Birth Date
has had a complete history and physical exam on
_____.
Month/Day/Year

Findings for this student are as follows:

This student has the following problems which may adversely affect his or her educational experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Illness/Chronic Condition ☐ Emotional/Social ☐ Behavior

☐ The pupil has a health condition which may require emergency action at school; e.g., seizures, allergies. *Specify below.*

☐ The pupil is on long-term medication. *Specify below*.

_____
_____

Comments and recommendations (attach additional sheet if necessary):_____
_____
_____
_____
_____

☐ This student may participate fully in the school program, including physical education activities.

☐ This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction)*
_____

☐ I would like to discuss information in the report with the school nurse.

☐ The school nurse may call our office for any concerns regarding this student's health.

Signature of Health Care Provider	Name (Please type or print)	Phone Number (including area code)
Address		