**Intro to New School Health Form**

“State law requires that every child entering public schools in N.C. receive a health assessment. The assessment must occur within 12 months prior to entering school. The medical provider, parent or guardian must provide a completed health assessment transmittal form to the principal of the school on or before the child’s first day of attendance.” *(NC DHHS 2/2016 - https://www2.ncdhhs.gov/dph/wch/families/kindergartenhealth.htm)*

Health Departments and primary care physician practices across North Carolina will be asked by families they serve to complete the new form at any time in the year. To assist in making sure the correct information about the child’s health is communicated to the school, the following guidance has been created for CCNC practices both as training is use of the new form and guidance on how it may be auto-populated:

- Students of any age (K-12) entering the NC public school system for the first time must receive a health assessment within 12 months prior to entering school. The physician, parent or guardian must provide a completed health assessment transmittal form to the school on or before the child's first day of attendance. There is a grace period of 30-days after the start of school for families to complete and submit the form. There is also a grace period for transition to the new form.

- Health Assessments should communicate the health concerns of parents and physicians and information that may affect learning

- The “toolkit” below contains:
  - A sample of the form with details in each section that should serve as prompts for what information would best meet the intent of the form
  - Two samples of a completed form, with fictitious data for information purposes only (no PHI!) to further example how to use the form. One sample is for a typical patient and the other is for a patient with complex conditions.
  - A blank copy of the form for use with real patient data

- The sections that begin with a blue highlight are areas of opportunity to auto-populate the form for practices that want to automate some of the form and create an electronic version for use with their EHR system.
### NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

#### PARENT to COMPLETE THIS SECTION

**Student Name:**  
- [ ] M  
- [ ] F  

**Birthdate (M/D/YYYY):**  

**School Name:**

**Hispanic of Latino Origin:**  
- [ ] Yes  
- [ ] No  

**Race:**  
- [ ] 1 Other Non-White  
- [ ] 2 White  
- [ ] 3 Black  
- [ ] 4 American Indian  
- [ ] 5 Chinese  
- [ ] 6 Japanese  
- [ ] 7 Hawaiian  
- [ ] 8 Filipino  
- [ ] 9 Other Asian  
- [ ] 10 Unknown  

**Home Address:**  
**City:**  
**State:**  
**County:**  

**Parent Information: Name of Parent, Guardian, or person standing in loco parentis:**  
**Telephone(s):**
- **Home:**
- **Work:**
- **Cell Phone:**

**Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):**

Concerns about your child’s health, weight, development or behavior (for parent/guardian to complete):
- Does anyone in your family have a condition that has affected their health, weight, development or behavior?  
- Has your child been seen by a provider for any health, weight, development or behavior concern?  
- Has your child had a dental exam by a dentist in the last 12 months?  
- Has your child had a well-visit or check-up in the last 12 months?  

**HEALTH CARE PROVIDER TO COMPLETE THIS SECTION**

**Medications prescribed for student:**

- Also indicate here is medication should be given and/or available at school.

**Student’s allergies, type, and response required:**

**Special diet instructions:**

**Health-related recommendations to enhance the student’s school performance:**

- For example: Sitting near the front of the classroom, special equipment needs.

**Vision screening information:**

- Passed vision screening:  
- Yes  
- No  

Concerns related to student’s vision:

- R -  
- L -  

Acuity Test Used –

Include here Acuity, Stereopsis. Also a referral to eye doctor for Passed = “No”. (Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease. Also indicate if the test was performed with corrective lenses. If child has a diagnosed vision condition and has had an eye exam in the last 12 months, screening is not necessary.)
Hearing screening information:

Passed hearing screening: Yes ☐ No ☐

Concerns related to student’s hearing: ☐

Indicate screening tool used (OAE or Audiometry). Also indicate results for each ear at 1000, 2000, and 4000 Hz.

If screen is failed, indicate if rescreening is scheduled due to middle ear fluid and how many weeks out to schedule. If referring, please indicate if to Audiologist/ENT. If screening is not necessary due to previously diagnosed hearing loss, please indicate that.

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

Pertinent History of Illnesses, Risks, or Developmental Problems: ☐

Results: ☐

BMI Percentile ☐

Developmental / Behavioral Screen ☐

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments: Be sure to indicate if assessment was completed in the child’s regular health care provider’s office.

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): __________________________

Practice/Clinic Name: ☐

Practice/Clinic Address: ☐

Practice/Clinic City: ☐

State: ☐

Zip: ☐

Phone: ☐

Fax: ☐

Provider Stamp Here:
## NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

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(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

### PARENT to COMPLETE THIS SECTION

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>(Last) Smith (First) Bill (Middle) John</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate (M/D/YYYY):</td>
<td>01/04/2004</td>
</tr>
<tr>
<td>School Name:</td>
<td>Ligon Middle</td>
</tr>
<tr>
<td>Hispanic of Latino Origin:</td>
<td>☐ 1 Yes ☐ 2 No</td>
</tr>
<tr>
<td>Race:</td>
<td>☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown</td>
</tr>
<tr>
<td>Home Address:</td>
<td>2200 Blue Street</td>
</tr>
<tr>
<td>City:</td>
<td>Raleigh</td>
</tr>
<tr>
<td>State:</td>
<td>NC</td>
</tr>
<tr>
<td>County:</td>
<td>Wake</td>
</tr>
<tr>
<td>Parent Information: Name of Parent, Guardian, or person standing in loco parentis:</td>
<td>Andrea Smith</td>
</tr>
<tr>
<td>Telephone(s):</td>
<td>Home: 919-414-2911</td>
</tr>
<tr>
<td></td>
<td>Work: 919-280-4570</td>
</tr>
<tr>
<td></td>
<td>Cell Phone: 919-212-3562</td>
</tr>
</tbody>
</table>

### HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

**Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):**

1. Anaphylaxis to peanuts, eggs and turkey
2. Moderate persistent asthma

**Medications prescribed for student:**

- **albuterol (proair HFA)**
- **epi pen**

**At home medications include:**

- **GVAR**

**Student’s allergies, type, and response required:**

- No medication allergies
- Anaphylaxis to peanuts, eggs and turkey – use of epipen (see plan)

**Special diet instructions:**

- No eggs, peanuts or turkey

**Health-related recommendations to enhance the student’s school performance:**

- Needs unlimited bathroom privileges

**Vision screening information:**

- Passed vision screening: ☒ Yes ☐ No
- Concerns related to student’s vision:
  - L 20/30 Snellen
  - Passed Strabismus
Hearing screening information:
Passed hearing screening: Yes ☐ No ☐
Concerns related to student's hearing: Pass at 1000, 2000, and 4000 Hz both ears
Audiometry

Recommendations, concerns, or needs related to student's health and required school follow-up:
1) Please evaluate and assist with classroom accommodations as needed
2) Refer to care plans attached (listed below)

School follow-up needed: Yes ☐ No ☐

Medical Provider Comments:
Child has basic understanding of need to avoid peanuts, eggs & turkey.
Child has been assessed for ability to be independent with use of his asthma inhaler.

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: Food Allergy and Anaphylaxis Network Plan

Plan for management of asthma

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: Greg Mills
Title: MD

Signature: [Signature]
Date (m/d/yyyy): 08/23/16

Practice/Clinic Name: Wake County Human Services Child Health Clinic
Practice/Clinic Address: 10 Sunnybrook Road

Practice/Clinic City: Raleigh State: NC Zip: 27610 Phone: 919-250-4570 Fax: 919-250-4587
NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

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(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Smith Mary Jane</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First)</td>
</tr>
<tr>
<td></td>
<td>(Middle)</td>
</tr>
<tr>
<td>Sex:</td>
<td>□ M □ F</td>
</tr>
<tr>
<td>Birthdate (M/D/YYYY):</td>
<td>07/04/2011</td>
</tr>
<tr>
<td>School Name:</td>
<td>Smith Elementary</td>
</tr>
<tr>
<td>Hispanic of Latino Origin:</td>
<td>□ 1 Yes □ 2 No</td>
</tr>
<tr>
<td>Race:</td>
<td>□ 1 Other Non-White □ 2 White □ 3 Black □ 4 American Indian □ 5 Chinese □ 6 Japanese □ 7 Hawaiian □ 8 Filipino □ 9 Other Asian □ 10 Unknown</td>
</tr>
</tbody>
</table>

Home Address: 111 Center Avenue City: High Point State: NC County: Greensboro

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Susan Smith

Telephone(s)

Home: 336-466-1234
Work: 336-216-1005
Cell Phone: 336-220-1200

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

none

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

none

Student's allergies, type, and response required:

NKA

Special diet instructions:

none

Health-related recommendations to enhance the student's school performance:

none

Vision screening information:

Passed vision screening: ☑ Yes ☐ No
Concerns related to student's vision:

20/20 20/20
Passed stereopsis
Hearing screening information:
Passed hearing screening: ☑ Yes ☐ No
Concerns related to student’s hearing:

Passed ASQ:3 Screening

School follow-up needed: ☑ Yes ☐ No

Medical Provider Comments:
1. well 5 year old child
2. BMI < 85%

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: Tony Thomas

Signature: __________________________

Title: MD

Date (m/d/yyyy): 8/24/16

Practice/Clinic Name:
High Point ABC Pediatrics

Practice/Clinic Address:
10 Elm Street
High Point, NC

Practice/Clinic City: High Point
State: NC
Zip: 27260

Phone: 336-222-1324
Fax: 336-222-1300
# NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

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(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

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<table>
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<tr>
<th>Student Name:</th>
<th>☐ M ☐ F</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td>(First) (Middle)</td>
</tr>
<tr>
<td>Birthdate (M/D/YYYY):</td>
<td>School Name:</td>
</tr>
<tr>
<td>Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No</td>
<td>Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown</td>
</tr>
<tr>
<td>Home Address:</td>
<td>City:</td>
</tr>
</tbody>
</table>

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

## 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:
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: [ ]

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Name: __________________________________________ Title: __________________________

Signature: ___________________________________________ Date (m/d/yyyy): ____________

Practice/Clinic Name: ___________________________ Practice/Clinic Address: ___________________________

Practice/Clinic City: ___________________________ State: ___________________________ Zip: ___________________________

Phone: ___________________________ Fax: ___________________________