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

**Enero 2016**

# CAROLINA DEL NORTE EVALUACION DE TRANSMISION DE LA SALUD

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

## ESTA SECCION COMPLETADA POR PADRES

**Nombre de Estudiante**: ☐ M ☐ F

(Apellido) (Primer Nombre) (Segundo Nombre)

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

**Origen Hispano o Latino** ☐ 1 Si ☐ 2 No

**Raza:** ☐ 1 Otro No-Blanco ☐ 2 Blanco ☐ 3 Afro-Americano ☐ 4 Nativo Americano ☐ 5 Chino ☐ 6 Japonés ☐ 7 Hawaiano ☐ 8 Filipino ☐ 9 Otro Asiático ☐ 10 Desconocido

**Direction:** **Ciudad:** **Estado:** **Condado:**

**Información de Padre: Nombre de Padre, Guardián Legal:**

**Telephone**

Casa:

Trabajo:

Cellular:

**Las preocupaciones de salud para ser compartidos con las personas autorizadas ( administradores de la escuela , maestros y otro personal escolar que requieren 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:**



Public Health
HEALTH AND HUMAN SERVICES

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**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:

**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: |

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Provider Stamp Here:

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