PART 1 HEALTH ASSESSMENT **To be completed by parent/guardian**				MCPS ID#
Student's Name (Last, First, Middle) (Preferred Name)	Birthdate (Mo., Day, Yr.)	Name of School		Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care? Name:	Address:		Phone No.	
When was the last time your child had a physical exam? Month	Year			
When was the last time your child had a dental exam? Month	Year			
Where do you usually take your child for dental care? Name:	Address:		Phone No.	

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any of the following? Please check yes or no below.

	Yes	No	Comments
Anaphylaxis or severe allergic reactions			
Allergies (Food, Insects, Medications, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavioral or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental Problems			
Diabetes			
Ear Problem or Deafness			
Eating Problems			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication? ☐ No ☐ Yes

If yes, name(s) of medications:____________________

Will your child require any medication to be administered in school? ☐ No ☐ Yes

If yes, name(s) of medications:____________________

Will your child require any emergency medications (epinephrine auto-injectors, inhalers, glucagon, Diastat, nebulized medication, etc.) to be administered in school? ☐ No ☐ Yes If yes, please list ____________________

Will your child require any special treatments (G-tube feedings, catheterizations, etc.) to be administered in school? ☐ No ☐ Yes

If yes, please list ____________________

I agree that by typing my name and today's date below, and submitting this form by electronic mail, I am intending that the below constitutes and is the equivalent to my personal signature.

Parent/Guardian Signature Date

PART II SCHOOL HEALTH ASSESSMENT
To be completed ONLY by authorized health care provider

MCPS ID#

Student's Name (Last, First, Middle) / (Preferred Name)	Birthdate (Mo., Day, Yr.)	Name of School	Grade

1. Does the child have a diagnosed medical condition? ☐ No ☐ Yes

   Specify ____

   ____

2. Does the child have a health condition which may require EMERGENCY ACTION while at school? (e.g., seizure, severe allergic reaction/anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please work with the school nurse to develop an emergency plan. ☐ No ☐ Yes

   Specify ____

   ____

3. Are there any abnormal findings on evaluation of concern? ☐ No ☐ Yes

   Specify ____

EVALUATION FINDINGS/CONCERNS

PHYSICAL EXAM	WNL	ABNL	Area of Concern	HEALTH AREA OF CONCERN	Yes	No
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings/health concerns.)

4. **RECORD OF IMMUNIZATIONS**: MDH 896 is required to be completed and attached by an authorized health care provider ***or*** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. ☐ No ☐ Yes

   ____

   (MCPS Form 525-13, *Authorization to Administer Prescribed Medication, Release and Indemnification Agreement and/or MCPS Form 525-14, Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis, Release and Indemnification Agreement for Epinephrine Auto Injector, must be completed for medication administration in school).*

6. Will the child require medically provided treatments, such as urinary catheterization, tracheostomy, gastrostomy feedings, and oral suctioning? ☐ No ☐ Yes If yes, MCPS Form 525-12, *Authorization to Provide Medically Prescribed Treatment, Release and Indemnification Agreement*, must be completed.

7. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction. ☐ No ☐ Yes MCPS Form 345-22 may be completed.

   ____

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PART II SCHOOL HEALTH ASSESSMENT *(continued)*
To be completed ONLY by authorized health care provider

8. **Screenings**	**Results/Date Taken**	**Comments**
Tuberculin Test (PPD, QFT, Questionnaire)		
Blood Pressure/Heart Rate		
Height		
Weight		
BMI %tile		
Blood Lead Testing (DHMH 4620)		
Hemoglobin/Hematocrit		

(Student Name) ____ has had a complete physical examination and has:

☐ No evident problem that may affect learning or full school participation ☐ Problems noted above

Additional Comments:

Name of Authorized Health Care Provider (Type or Print)	Phone No.	Authorized Health Care Provider Signature	Date