जनवरी 2016

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

उत्तर क्यारोलिनाको स्वास्थ्य मूल्याङ्कन सम्बन्धी फारम

यो फारम र यस फारममा भएको जानकारी यसमा नाम भएका विद्यार्थीहरु उपस्थित हुने विद्यालयको फाइलमा गोप्य रूपमा राखिनेछ तथा सार्वजनिक रेकर्डमा राखिने छैन।

(उत्तर क्यारोलिना सार्वजनिक शिक्षा विभाग र स्वास्थ्य तथा मानव सेवा विभागद्वारा अनुमोदन गरिएको)

यस खण्डलाई अभिभावकले परा गर्नपर्छ

विद्यार्थीको नाम:

(अन्तिम) (प्रथम) (बिचको)

जन्म दिन (महिना/दिन/वर्ष): विद्यालयको नाम:

घरको ठगाना: शहर: राज्य: देश:

अभिभावकको बारेमा जानकारी: आमा-बुवा, अभिभावक तथा कानूनी रुपमा अधिकार प्राप्त अभिभावकको नाम : टेलिफोन (हरू)

घर:

कार्यालय:

सेल फोन:

स्वास्थ्य सम्बन्धी समस्याहरु अधिकारिक व्यक्ति (विद्यालय प्रशासकहरु, शिक्षकहरु र आफुलाई तोकिएको जिम्मेवारी पूरा गर्न यस्ता जानकारी आवश्यक भएका अन्य विद्यालय कर्मचारीहरु) सँग साझा गर्नुपर्छ:

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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