ALABAMA STATE DEPARTMENT OF EDUCATION
HEALTH ASSESSMENT for School Year: 2026-2027
Also, downloadable on the JCS District Website

To Parent or Guardian:
The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept strictly confidential.
PLEASE complete both pages of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number	Cell Telephone Number	Additional Phone Number	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First, Middle)	Work Phone Number

Transportation
□ Bus Rider Bus Number □ Car Rider □ Special Needs Bus □ After School

Part I – Health Information

Place where your child receives regular health care:
Physician's Name: _____

Address: _____
_____

Telephone: _____
□ Community Health Center
□ Health Department
□ Hospital Clinic
□ No Regular Place
□ Private Doctor/HMO

Your child's Insurance Information:

□ ALL KIDS
□ Medicaid
□ No Insurance
□ Other
_____
□ Private Insurance

Place your child receives dental care:
Dentist's Name: _____

Address: _____
_____

Telephone: _____
□ Community Health Center
□ Health Department
□ Hospital Clinic
□ No Regular Place
□ Private Dentist/HMO

Preferred Hospital: _____

Part II – Medical History Medical Equipment/Procedures Required at School

□ Catheter □ Gastric Tube □ Nebulizer Treatments □ Oxygen Supplement □ Tracheostomy

□ Vagal Nerve Stimulator (VNS) □ Ventilator □ Wheelchair □ Walker

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure). Please see your school nurse.
Please Complete Form on Next Page (Signature Required)

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Name of Student: _____Part III – Medical History

□ **YES** □ **NO**	**KNOWN HEALTH PROBLEMS** If **NO**, go directly to the bottom of the page and provide parent/guardian signature If **YES**, and diagnosed by a physician, answer each question below.
□ **YES** □ **NO** □ **YES** □ **NO**	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication? □At school □ At Home
□ **YES** □ **NO**	**Allergies:** □ Hives/rash □ Medications □ Other □ **Food** _____ □ Breathing difficulty □ Epi-pen □ **Insects** _____ □ **Environmental** _____ □ **Medications** _____
□ **YES** □ **NO**	**Asthma** □ Uses an inhaler at school □ Uses an inhaler at home
□ **YES** □ **NO**	**Blood/Bleeding Problems:** □ **Hemophilia** □ **Von Willebrand's** □ **Other** □ **Requires medication** *Please explain:*
□ **YES** □ **NO**	**Frequent Nose Bleeds:** *Please explain:*
□ **YES** □ **NO**	**Cancer/Leukemia:** *Please explain:*
□ **YES** □ **NO**	**Cerebral Palsy:** *Please explain:*
□ **YES** □ **NO**	**Cystic Fibrosis:** *Please explain:*
□ **YES** □ **NO**	**Dental Problems:** *Please explain:*
□ **YES** □ **NO**	**Diabetes** □ **Type 1 Diabetes** □ Monitors Blood Sugars at school □ Requires Insulin at school □ Insulin pump □ Glucagon order □**Type 2 Diabetes** □ Managed with diet □ Oral medication
□ **YES** □ **NO**	**Emotional/Behavioral/Psychological:** *Please explain*:
□ **YES** □ **NO**	**Gastrointestinal/Stomach Problems: Please explain:**
□ **YES** □ **NO**	**Genetic / Rare Disorders: Please explain:**
□ **YES** □ **NO**	**Headaches: Please explain:**
□ **YES** □ **NO**	**Hearing Problems:** □ Right Ear □ Left Ear □ Both ears □ Tubes □ Hearing loss □ Hearing aid □ Cochlear Implant
□ **YES** □ **NO**	**Heart Conditions:** □ **Activity restrictions:** □ **Medications taken at home:** *Please explain:*
□ **YES** □ **NO**	**Hypertension (High Blood Pressure):** *Please explain:*
□ **YES** □ **NO**	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
□ **YES** □ **NO**	**Kidney/Bladder/Urinary Problems:** *Please explain:*
□ **YES** □ **NO**	**Scoliosis:** □ No Treatment □ Wears Brace □ Surgery □ Family History
□ **YES** □ **NO**	**Seizures/Convulsions:** Type of seizure: _____ Medications: □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other _____ *Please explain:*
□ **YES** □ **NO**	**Sickle Cell**: □ Anemia □ Trait
□ **YES** □ **NO**	**Shunt:** □ VP shunt *Please explain:*
□ **YES** □ **NO**	**Spina Bifida:**
□ **YES** □ **NO**	**Special Diet:** *Please explain:*
□ **YES** □ **NO**	**Vision Problems:** □ Wears glasses □ Wears contacts □ Other _____
□ **YES** □ **NO**	**Other Medical Conditions:** *Please include **any** medications taken at home only.*

Required Signatures

Parent(s) or Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date:_____

Please complete this form, remove from the handbook, and return to the school office.
Keep the handbook for future reference.