**January 2016rev **

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| **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**:  (Last) (First) (Middle) |
| **Birthdate (M/D/YYYY): School Name:** |
| **Home Address: City: State: County:** |
| **Parent Information: Name of Parent, Guardian, or person standing in**  **Telephone(s)**  **loco parentis:**    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):** |
| **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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www.clevelandcountyschools.org

**Cleveland County Schools**

***Office of School Readiness***

***308 West Marion Street, Shelby, NC 28150***

**704-476-8064**

CLEVELAND COUNTY PRESCHOOL

**FEDERAL REQUIREMENT FOR HEAD START**

Lead Level Screening at age 2 or after \_\_\_\_\_\_\_\_\_ µg/dl Date:\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_Within Normal Range

\_\_\_\_\_\_\_\_Needs Follow-Up

HGB \_\_\_\_\_\_\_\_\_\_ or HCT\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_Within Normal Range

\_\_\_\_\_\_\_\_Needs Follow-Up

Medical Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice/Clinic Name & Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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