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| **FORMULARIO DE EVALUACIÓN DE SALUD Y TRANSMISIÓN DE CAROLINA DEL NORTE** | | | | | |
| Este formulario y la información en este formulario serán archivados en la escuela a la que asistió el estudiante, es confidencial y no es un registro público.  (Aprobado por el Departamento de Instrucción Pública de Carolina del Norte y el Departamento de Salud y Servicios Humanos) | | | | | |
| **LOS PADRES DEBEN COMPLETAR ESTA SECCIÓN** | | | | | |
| **Nombre del estudiante**: |  | | | |  |
| (Apellidos) (Primer nombre) (Segundo nombre) | | | | |
| **Fecha de nacimiento (mes/día/año):** | **Nombre de la escuela** | | **:** |  |  |
| **Dirección:** |  | **Ciudad:** |  | **Estado:** | **Condado:** |
| **Información de los padres, tutores, apoderados o personas responsables de su cuidado:** | | | | **Teléfono (s)** Casa:  Trabajo:  Celular: |  |
| **Las condiciones de salud para ser compartidas con las personas autorizadas (administradores de la escuela, maestros y otro personal escolar que requiera 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:** | | | | | |
| **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): | | | | |
| Practice/Clinic Name: | | | Practice/Clinic Address: | |
| Practice/Clinic City: | State: | Zip: | Phone: | Fax: |
| Provider Stamp Here: | | | | |