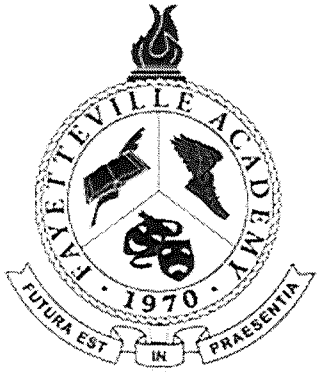

Dear Parent/Guardian:

A Kindergarten Health Assessment is now required for those students entering Kindergarten at Fayetteville Academy. The Health Assessment must be completed no earlier than one year prior to school entry by a licensed healthcare provider (doctor or clinic). All parts of the Health Assessment form must be completed and returned to Fayetteville Academy. This form along with current, up to date immunizations are due to the school nurse, Lauren Jenkins at the start of school with the deadline 30 days after the start of school, which is September 19, 2019. As a reminder, children need their last set of immunizations (DTaP, Polio, MMR, Varicella) in addition to other missed vaccines before starting school. You must provide proof of these immunizations from the healthcare provider as well.

We have attached the Health Assessment form to be completed in this email. It is also available on our website or in the Lower School Office. If you have any questions or concerns please contact Lauren Jenkins RN, BSN at 910-868-5131 Ext: 3323. Have a wonderful summer and we look forward to seeing you in August.

Sincerely,

Lauren Jenkins RN BSN

January 2016rev

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

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 loco parentis:

Telephone(s)

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:

NC Public Health
HEALTH AND HUMAN SERVICES

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:

Public Health
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