



Dear Parent/Guardian:

A Kindergarten Health Assessment is required for those students entering Kindergarten at Fayetteville Academy for the 2020-2021 school year. The Health Assessment must be completed no earlier than one year prior to school entry by a licensed healthcare provider. This form along with current, up to date immunizations are due to the school nurse, Lauren Jenkins prior to or at the start of school. The deadline being 30 days after the start of school, which falls on September 30, 2020. As a reminder, your child should be up to date on the follow immunizations: *DTaP, Polio, MMR, Varicella, Hep B, HIB, and Pneumococcal*. You must provide proof of these immunizations from the healthcare provider. If you have questions or concerns please contact Lauren Jenkins at 910-868-5131 Ext: 3323 or ljenkins@fayacademy.org

Sincerely,

Lauren Jenkins RN BSN



PUBLIC SCHOOLS OF NORTH CAROLINA

State Board of Education | Department of Public Instruction

January 2016rev

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:





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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:

