2020/2021

HEALTH ASSESSMENT

PART II

13500 Layhill Road, Silver Spring, MD 20906
301-576-2800 fax: 301-576-2805
www.barrie.org

To be completed ONLY by Physician/Nurse Practitioner

Child's Name (Last, First, Middle)	Birthdate (Mo/Day/Yr)	Sex (M/F)	Grade

1. Does the child have a diagnosed medical condition? ☐ No ☐ Yes
Specify _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at Barrie? (e.g., seizure allergic reaction/anaphylaxis to food or insect sting, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with the school nurse to develop an emergency plan". ☐ No ☐ Yes
Specify
_____
_____

3. Are there any abnormal findings on evaluation for concern? ☐ No ☐ Yes
Specify
_____

EVALUATION FINDINGS/CONCERNS

PHYSICAL EXAM	WNL	ABNL	HEALTH AREA OF CONCERN	YES	NO
Head			Attention Deficit/Hyperactivity		
Eyes			Behavior/Adjustment		
ENT			Development		
Dental			Hearing		
Respiratory			Immunodeficiency		
Cardiac			Lead Exposure/Elevated Lead		
GI			Learning Disabilities/Problems		
GU			Mobility		
Musculoskeletal			Nutrition		
Neurological			Physical Illness/Impairment		
Skin			Psychosocial		
Endocrine			Speech/Language		
Psychosocial / Mental and Emotional Health			Vision		
			Other		

REMARKS: (Please explain any abnormal findings/health concerns.)

4. **RECORD OF IMMUNIZATIONS:** DHMH 896 is required to be completed by a health care provider ***or*** computer generated immunization record must be provided (Attach separately)

5. Is the child on medication? If yes, indicate medication and diagnosis. ☐ No ☐ Yes
_____

(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity? If yes, specify nature and duration of restriction. ☐ No ☐ Yes
_____
_____

7. **Screenings** Tuberculin Test	**Results**	**Date Taken**
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test		

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PART II HEALTH ASSESSMENT (continued)
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(Child's Name) _____ has had a complete physical examination and has:

☐ No evident problem that may affect learning or full participation in the program ☐ Problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Physician/Nurse Practitioner Signature	Phone	Date