NORTH WALL
SCHOOLS

Health Assessment

I authorize _____, _____ to share information
(Physician's Name) (Phone Number)
regarding_____. _____
(Child's Name) (Parent Signature)
Date of visit _____

Reason for visit: _____

The child is in good physical health: YES NO If no, Explanation: _____

The child may attend school/
an early childhood program: YES NO If no, Reason: _____

All immunizations are up to date: YES NO If no, Reason: _____

Screening tests given: 1. _____ NORMAL ABNORMAL
Follow up required: _____

2. _____ NORMAL ABNORMAL
Follow up required: _____

3. _____ NORMAL ABNORMAL
Follow up required: _____

Medications prescribed:

Medication Name	Reason for Medication	Dosage

_____
Signature of physician

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