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

9408 North Wall Spokane, WA 99218 p:509.466.2695 f:509.465.5374 www.northwallschools.com