**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Teacher Name: Click or tap here to enter text.

**Vision**

Date of most recent screening: Click or tap here to enter text. Referral Date (if necessary) Click or tap here to enter text.

Right: Click or tap here to enter text. Left: Click or tap here to enter text.

**Hearing**

Date of most recent screening: Click or tap here to enter text. Referral Date (If necessary) Click or tap here to enter text.

Right:  passed  failed

Left:  passed  failed

**Current medications administered at school:**

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Excluding routine medication visits, how many times has the student been to the nurse's office:

This school year: Click or tap here to enter text.

Last school year: Click or tap here to enter text.

Does the student have or has the student had an Individual Healthcare Plan or has the student received regular health services?

No  Yes If yes, attach a copy of the plan. If you do not have a copy of the plan, explain. Click or tap here to enter text.

Do you have any health concerns about this student?  No  Yes

If so, describe your concerns. Click or tap here to enter text.

Has the parent provided you with any information regarding a physical or mental impairment of the student?  No  Yes

If so, what condition was identified or diagnosed? Click or tap here to enter text.

Attach any written documentation regarding a physical or mental impairment.

Click or tap here to enter text. Date: Click or tap here to enter text.

Name and title of person completing form

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Signature