**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature