|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| LAST NAME |  | FIRST NAME |  | SCHOOL YEAR |  |
| SCHOOL |  | SCHOOL ID# |  | D.O.B. |  | GENDER |  | GRADE |  |
| REFERRING TEACHER  |  | DATE of REQUEST |  |
| Vision:Date of last exam: | Hearing:Date of last exam: | Height: | Weight: | Skin: |

Is the student currently taking any medication? **☐Yes ☐No**

If yes, and if parental approval has been obtained, what medications is the student taking?

Are there any known medical problems? **☐Yes ☐No**

If yes, please describe the condition and its implications unless this information should remain confidential.

What concerns, if any, do you have about this student’s physical health?

Have there been any changes in this student’s physical health status? **☐Yes ☐No**

If yes and parental approval has been obtained, what changes have occurred in this student’s physical health status?

What concerns do you have about this student’s emotional health?

Have there been any changes in this student’s emotional health? **☐Yes ☐No**

If yes and parental approval has been obtained, what changes have occurred in this student’s emotional health?

Is this student a frequent visitor to the Nurse’s Office? **☐Yes ☐No**

If yes, please list/attach dates and reasons for the current school year:

From your perspective as a school nurse, do you have any other comments or concerns?