Confidential Medical Information

STUDENT HEALTH SUMMARY FROM THE SCHOOL NURSE

Student:	B.D.:	Date:
Teacher:	Grade:	School:
SST: ☐ Initial IEP: ☐ Triennial: ☐ Other:		
Scheduled Date of Meeting (if known):		

SUMMARY OF SIGNIFICANT MEDICAL OR HEALTH FINDINGS:
School Health Records ☐ Parent Contact ☐

MEDICATION: Yes: ☐ No: ☐
Name:

Possible Side Effects:

Name:

Possible Side Effects:

VISION: Acuity Date:	<u>Far</u> Rt. Eye: Lt. Eye:	<u>Near</u> Rt. Eye: Lt. Eye:	With Lenses: ☐ Without Lenses: ☐	Referred for Care: Yes: ☐ No: ☐

HEARING: Date:	Right Ear:	Left Ear:	Referred for Care; Yes: ☐ No: ☐

Vision/Hearing: ❑Within normal limits
Comments:

School Nurse: _____