|  |  |  |  |  |
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| **Student:** | **ID #:** | **DOB:** | **Gr.:** | **Campus:** |

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| **School Nurse:** |

**Directions:**  To be completed by campus school nurse ***prior*** to initial meeting for screening.

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| **Vision:** | | Date of Screening: | | Position: |
|  | | Person Conducting Screening: | | Near Vision |
| **Yes** | **No** | Results: | | Distance Vision |
|  |  | Did the screening indicate a need for further assessment or adjustment?  If ***YES***, explain: | | |
|  |  | Has follow-up treatment been recommended?  If ***YES***, explain: | | |
| **Hearing:** | | Date of Screening: |  | |
|  | | Person Conducting Screening: | Position: | |
|  | | Type of Screening: |  | |
| **Yes** | **No** | Results: |  | |
|  |  | As a result of the screening, is there any indication of a need for further assessment or adjustment?  If ***YES***, explain: | | |
|  |  | Has follow-up treatment been recommended?  If ***YES***, explain: | | |
| **Health:** | | **Medical Diagnosis:** | | |
| **Yes** | **No** |  | | |
|  |  | Does student exhibit any signs of health or medical problems?  If ***YES***, explain: | | |
|  |  | Is there a need for further assessment or referral of a medical problem?  If ***YES***, explain: | | |
|  |  | Is student receiving any medication at school?  If ***YES***, specify: | | |
|  |  | Does this student require adaptive equipment or facility adaptation for accessibility?  If ***YES***, specify: | | |
|  |  | Does this student make frequent visits to the nurse’s office?  If ***YES***, how often/how many? | | |

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| Nurse’s Signature | Date |