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

|  |
| --- |
| **School Nurse:** |

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

|  |  |  |
| --- | --- | --- |
| **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?  |

|  |  |
| --- | --- |
| Nurse’s Signature | Date |