_____
Student's Name

MEDICAL REVIEW

Interview Date:_____ School Nurse:_____

IDENTIFYING INFORMATION		
Student's Name		Name of School
Sex	DOB	Home District
Name of Parents/Guardian		Class/Grade
Home Address		Teacher
Home Phone Number		Work Phone Number

REFERRAL AND ASSESSMENT CONCERNS
Teacher's Perspective (How the student's health may be affecting his/her academic performance or access to the curriculum):
Attendance
Reason for assessment:
Parent Perspective:

DEVELOPMENTAL HISTORY
Prenatal History:
Overall health of the mother during pregnancy:
Mother's Use of medication during the pregnancy:
Mother's use of illicit medications, smoking, alcohol:
Suspected maternal exposure to diseases or toxins:

Birth History:	
Birth Order: ____ out of _____	Birth weight:
Apgar scores if known: ____ at 1 minute	____ at 5 minutes
Delivery type: ____ cephalic ____ cesarean section	
Description of the labor and delivery:	
Condition of the infant following the birth:	
Infant discharged from hospital ____ days following birth, ____with ____without mother.	
Development:	
Special medical or developmental services needed in the 1st three years of life:	
Achievement of developmental milestones (age):	
Sat Unsupported:	Crawled:
Cruised along furniture:	Walked alone:
Spoke single words:	Spoke in simple sentences:
Toilet trained day:	Toilet trained night:
Current development:	

_____
Student's Name

Parent's perception of student's motor skills:	
Fine motor:	Gross motor:
Typical activities:	

CURRENT OR PAST MEDICAL HISTORY

- ☐ Allergies: _____
- ☐ Respiratory/Asthma: _____
- ☐ Skin: _____
- ☐ Oral/Motor: _____
- ☐ Ears/Nose/Throat: _____
- ☐ Heart/Blood: _____
- ☐ Stomach/bowel: _____
- ☐ Kidney/Urinary: _____
- ☐ Neurological: _____
- ☐ Endocrine: _____
- ☐ Musculoskeletal/Orthopedic: _____
- ☐ Psychological: _____
- ☐ Other: _____

_____

_____

_____

_____

HEALTH RECORDS

Date of Last Physical	
Height	Weight
Last Vision Screening Date	Last Hearing Screening Date
Primary Care Physician	
Nutrition	
Sleep Habits	
General Behavior	

MEDICATIONS

Medication Name	Dosage	Frequency	Reason for Taking	Prescribing Physician

_____
Student's Name

SIGNIFICANT MEDICAL NEEDS
Illnesses
Hospitalizations
Surgeries
Accidents/Injuries:

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VISION/HEARING SCREENING (If requested)

Screening Date:_____ School Nurse:_____

VISION

- ☐ Passed
- ☐ Failed
- ☐ Could not condition

Date of last vision exam:_____

Notes:_____

_____

HEARING

- ☐ Passed
- ☐ Failed
- ☐ Could not condition

Date of last hearing exam and/or audiological:_____

Notes:_____

_____

Student's Name

NURSING SERVICES (if relevant)

Including the identification of the school health services or school nurse services necessary to enable a student with a disability to receive FAPE as described in his or her IEP.

EDUCATIONALLY RELEVANT MEDICAL FINDINGS

Include the identification of the medical conditions and other health-related issues that are likely to adversely affect a child's educational performance.

SCHOOL NURSE RECOMMENDATIONS

Include an analysis of the information gathered for the purpose of:

(a) determining the medical, school health, and/or school nurse services that should be provided during the school day and

(b) develop a proposed plan that provides for specific accommodations, modifications, or interventions to be implemented when educationally relevant medical, school health and/or school nurse findings are made, which shall include annual goals, short-term objectives, and ongoing evaluation.

Signature, School Nurse

Date