Nurse Screening Form

Student: _____ **ID#:** _____ **Gr.:** _____ **D.O.B.:** _____

Campus: _____ **School Nurse:** _____

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

VISION:

Date of Screening:_____ Person Conducting Screening:_____ Position_____

Results: _____ Passed: YES ☐ NO☐

If student did not pass screening what is the recommendation? _____

HEARING:

Date of Screening:_____ Person Conducting Screening:_____ Position:_____

Type of Screening: _____ Results: _____ Passed: YES ☐ NO☐

If student did not pass screening what is the recommendation? _____

HEALTH:

Are there any signs of health or medical problems with this student?
If ***YES***, explain: _____

Does the student need further assessment or referral of a medical problem?
If ***YES***, explain: _____

Is the student receiving any medications at school?
If ***YES***, specify: _____

Does this student require handicap accessibility?
If ***YES***, specify: _____

Has frequent visits to the nurse's office occurred?
If ***YES***, how often/how many? _____

_____ _____
Nurse's Signature Date