

PROFESSIONAL SCHOOL NURSE HEALTH FORM

Student: _____ School: _____

DOB: _____ Grade Level: _____ Room Number: _____

Please complete and return this form by: _____ To: _____

Health History

Is the student currently taking any medication? Yes No

If yes please explain unless information should remain confidential: _____

Are you aware of any prior use of medication by the student? Yes No

If yes please explain unless information should remain confidential: _____

Are you aware of any medical or other condition that could interfere with the student's ability to perform in school? Yes No

If yes please describe the condition and its implications unless this information should remain confidential: _____

Health Assessment

Height: _____ Weight: _____ Vision: _____

Hearing: _____ Skin: _____ Posture: _____

Socialization

Observable behaviors: _____

Behavioral changes: _____

Physical Appearance (e.g. personal hygiene, fatigue, attire, etc.): _____

Visits to Nurse

Frequency/Number: _____ Reasons: _____

Physical Education Excuses

Number: _____ Reasons: _____

Health Summary (Use additional space, if necessary): _____

School Nurse Signature: _____

Date: _____