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| **BROWNSVILLE INDEPENDENT SCHOOL DISTRICT STUDENT HEALTH INFORMATION**  |  |

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| Student:  | ID#:  | DOB:  |
| Campus:  | Grade:  | Nurse: |

**DIRECTIONS:**  To be completed by campus school nurse.

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| **VISION:**  | Date of Screening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person Conducting Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results: Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Right: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **YES**  | **NO**  |   |
|   |   | 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Right: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **YES**  | **NO**  |   |
|   |   | 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:**  |   |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_