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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_