

ORANGE TOWNSHIP PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES

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Barbara L. Clark, Director

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HEALTH AND MEDICAL SUMMARY

TO: SCHOOL NURSE
FROM: CHILD STUDY TEAM

RE: _____ **DATE:** _____

HEALTH HISTORY

Is the student currently taking any medication? If yes, please identify: _____

Are you aware of any prior use of medication by the student? If yes, identify each medication and condition treated. _____

Are you aware of any medical or other condition that could interfere with the student's ability to perform in school? If yes, please describe the condition and its implications. _____

HEALTH ASSESSMENT

Date of Birth: _____

Height: _____

Vision: _____

Skin Condition: _____

Comments: _____

Weight: _____

Hearing: _____

Posture: _____

SOCIALIZATION

Observable behaviors: _____

Behavioral changes: _____

Comments: _____

PHYSICAL APPEARANCE (e.g., personal hygiene, fatigue, odor of smoke, attire)

Visits To Nurse: Frequency/Number: _____ Reasons: _____

Physical Education Excuses: Number: _____ Comments: _____

Other Pertinent Information: _____

