STRATFORD SCHOOL DISTRICT
INTERVENTION AND REFERRAL SERVICES
SCHOOL NURSE/SCHOOL HEALTH FORM
Confidential

STUDENT: _____ GRADE: _____
TEACHER: _____ DATE: _____

Please complete and return to _____ by: _____

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: _____ Weight:
Height:
Skin:

Posture:

Vision: Left___/___
Right ___/___

Hearing: Left _____ Right
Comments:

Socialization
Observable behaviors:
Behavioral changes:
Comments:

Physical Appearance (e.g., personal hygiene, fatigue, odor of smoke, attire)

(please continue on reverse side)

Visits to Nurse
Frequency:

Reasons:

Physical Education Excuses
Number:

Reasons:

Comments:

Attendance
Number of times late: _____ Number of times absent:

Other Pertinent Information

Signature of School Nurse:

Date completed:

Revised December 7, 2012