| **Student Name:**  | **Birth Date** | **School Grade** | **Student #** |
| --- | --- | --- | --- |
| Parent/Guardian:  |
| Parent/Guardian:  |
| Primary Care Provider/phone/fax**:** |
| Specialist/phone/fax**:** |
| Source of Information**:** |
| CURRENT HEALTH ISSUES | *CURRENT MEDICATIONS, ALLERGIES, ACTIVITY/DIET RESTRICTIONS, SLEEP/REST PATTERNS* |
| PERTINENT HEALTH HISTORY | *Surgeries, hospitalizations,* |
| *Systems Assessment: √ = Normal NA=not assessed Indicate if performed by RN or source of records reviewed* |
| Eyes |  | Date Vision Results |  |
| Ears, Nose |  | Date Hearing/Results |  |
| Mouth, throat |  | Dental Screening |  |
| Cardiovascular |  Blood Pressure       | Date      Height       Weight       BMI            % |
| Lungs |  | Abdomen |  |
| Extremities/joints |  | Genitalia |  |
| Spine |  | Skin, lymph nodes |  |
| Immunizations |  |
| **[ ]  Health Care plan not indicated at this time****[ ]  Health care plan initiated and sent to**       | **DATE****health care plan signed by parents****health care plan signed by health care provider****staff trained and delegated for health care plan** |
|  |
| licensed school nurse signature date |
| **Preferred Hospital:** |  | **Emergency Contact:** |  |
| **Nursing Outcome(s)** |