| **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)** | | | | | | | |