



STUDENT SERVICES
HEALTH ASSESSMENT

Informant _____
Relationship to Student _____
Date _____
Birthdate _____ Age _____
Grade _____ Room Number _____
Home Phone _____
Work Phone _____
Date of Last Visit _____
Date of Last Visit _____

STUDENT'S LEGAL NAME _____
School _____
Parent/Guardian _____
Address _____
Health Care Provider _____
Dentist _____

CURRENT HEALTH (Present medications) _____

PAST MEDICAL HISTORY

Pregnancy _____ Birth _____
Infancy _____ Ear Infections _____
Serious Illnesses _____
Hospitalizations _____ Operations _____
Injuries _____ Allergies _____

DEVELOPMENTAL HISTORY

Sat _____ Walked _____ Single Words _____
Sentences _____ Toilet Trained _____ Tricycle _____

FAMILY HISTORY

Maternal

Paternal

SOCIAL HISTORY

SOCIAL HISTORY

PHYSICAL EXAMINATION

Height _____ % _____ B.P. _____ % _____ Vision R _____ L _____

Weight _____ % _____ Head Circ. _____ % _____ Hearing R _____ L _____

GENERAL (General appearance and behavior during exam)

Head _____ Eyes _____
Ears _____ Nose _____
Throat _____ Teeth _____
Neck _____ Chest/Lungs _____
Heart _____ Skin _____
Extremities _____ Other _____

NEUROLOGICAL

Cranial Nerves _____

Sensation _____

Muscle Mass/Strength _____

Deep Tendon Reflex _____

Fine Motor _____

Gross Motor _____

Right/Left Preference _____

Right/Left Orientation _____

VISUAL-MOTOR-PERCEPTION

Form Copying _____

Draw a Person - Use Additional Sheet _____

NURSE ASSESSMENT REPORT

A. General health (Explain any abnormal conditions.)

B. Health factors (past or present) that affect ability to function in school. Explain.

C. Plan (recommendtions, referrals and further action required).

Signature of Interviewer/Examiner

Position/Title

Date