REQUEST FOR SCHOOL NURSE SERVICES

SCHOOL:_____ **TEACHER:**_____

DATE:_____ **ATTENTION:**_____

STUDENT INFORMATION

Name:	DOB:	Grade:
Parent/Guardian::		
Address:		
Telephone: Home:	Cell:	Work:

IEP INFORMATION

IEP Meeting : Date:	Time:	Location:
Exceptionality:		
Does the student currently have a Classroom Health Care Plan: Yes:		No:
Date of current Classroom Health Care Plan:		

SERVICES REQUESTED:

Classroom Health Care Plan :	Yes:	No:
Vision and Hearing:	Yes:	No:

MEDICAL INFORMATION

Brief description of medical condition or medical procedures:
Medication being taken if known: **At Home:**
At School:
Date of last Vision and Hearing:

NURSE ASSESSMENT RESULTS

Vision Screening Results : Date:
Hearing Screening Results: Date:
Classroom Health Care Plan needed and attached:
Classroom Health Care Plan not needed:
Other:

Nurse's Signature: _____

Please Return this form to Special Ed Teacher.