

Please complete and return to _____ by _____. Thank you for your cooperation.

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

COMPREHENSIVE EVALUATION HEALTH ASSESSMENT

STUDENT'S NAME: _____ **D.O.B:** _____ **GRADE:** _____

1. **Vision:** _____ **Glasses:** _____ **Hearing:** _____
Date Results Yes No Date Results

2. **Observation:**

a. Multiple Choice (Mark all areas of concern - suspected or otherwise)

- ___ i. Hygiene _____
- ___ ii. Substance/alcohol abuse _____
- ___ iii. Nutrition _____
- ___ iv. Headaches _____
- ___ v. Stomachaches _____
- ___ vi. Fatigue _____
- ___ vii. Irritability _____
- ___ viii. Other _____

3. **How often does the student come to the health room/nurse office?**

Rarely, Daily, Weekly, Monthly (Circle one). What is the reason for the visit? _____

4. **Does the student have a medical/mental health diagnosis?** (Check) _____ Yes _____ No

If Yes: Diagnosis _____

5. **Does the student take medication?** (Check) _____ Yes _____ No _____ I do not know.

Last Parent Contact: _____

Yes: Medication Name: _____

Does the student take the medication at Home or School (Circle one or both)

6. **Summary and Conclusions for the Team to consider:**

Summary of Health history known to the school:

Conclusions:

- ___ a) The student has a health condition that appears to impact his/her educational performance.
- ___ b) The student has a health condition that does not appear to impact his/her educational performance.
- ___ c) The student does not have a documented health condition.
- ___ d) Other _____

Nurse's Signature

Date

School