STUDENTS WITH SPECIAL HEALTH CARE NEEDS
SCREENING/ REFERRAL CHECKLIST

STUDENT: ______________________________ SCHOOL: ________________ GRADE: ________

PARENT: ______________________________ ADDRESS & PHONE NUMBER: ______________________

Person Completing Form: ____________________ Date: ________________

Source of Information: ____

DOES THE STUDENT:

	YES	NO	COMMENTS
1. Experience severe allergic reactions that require immediate medications, i.e., Epi-Pen?			Describe: Drug Allergies:
2. Have a medical diagnosis of a chronic health problem (i.e., diabetes, tuberculosis, ADD, seizures, cystic fibrosis, asthma, muscular dystrophy, liver disease, digestive disorders, liver disease, digestive disorders, respiratory disorders, hemophilia)? Condition: ______________________			Describe/History: Physician:
3. Receive medical treatments during or outside the school day (i.e., oxygen, gastrostomy care, tracheostomy care, suctioning, injection)? Condition: ______________________			Treatment:
4. Experience frequent absences due to illness or frequent hospitalizations?			Hospital:
5. Receive ongoing medication at home or school for physical or emotional problems (i.e., seizures, heart condition, allergy, asthma, cancer, depression, ADD/ADHD)?			Medication name & dose: Change in Med. since last IEP: ____yes ____no Med Given : (√) ____ home ____school
6. Require adjustments of the school environment or schedule due to a health condition (i.e., seizures, limitations in physical activity, periodic breaks for endurance, part- time schedule, building modifications for access)?			
7. Require environmental adjustments to classroom or school facilities (i.e., temperature control, refrigeration/medication storage, availability of running water)?			
8. Require major safety considerations (i.e., special precaution in lifting, positioning, special transportation, emergency plan, special safety equipment, special techniques for positioning, feeding?			
9. Require a special diet (i.e., blended, soft, low salt, low fat, liquid supplement)?			
10. Require assistance with activities of daily living (i.e., eating, toileting, walking)?			

If the answer to any question is yes, refer to the school nurse.

REFERRED TO: ______________________________ Date: ____________ FAX: 263-3456

IEP DATE: ______________________________________ TIME: ________________

NURSE COMMENTS:

________ Teacher Review & Update Current IHP

________ Nurse Develop New IHP

Other: ____