SOLVAY UNION FREE SCHOOL DISTRICT
COMMITTEE ON SPECIAL EDUCATION
NURSING APPRAISAL FORM

Student Name **Date of Birth**

Parent/Guardian

Address **Phone**

Student's Physician **Phone**

MEDICAL HISTORY:

☐ Allergies	☐ Frequent colds	☐ Pneumonia	☐ Urological
☐ Asthma	☐ Gastrointestinal	☐ Rheumatic fever	☐ Whooping cough
☐ Cancer	☐ Heart condition	☐ Rubella	☐ Other
☐ Chickenpox	☐ Measles	☐ Seizure disorder	☐ Other
☐ Diabetes	☐ Neurological	☐ Serious injury	☐ Other
☐ Ear/nose/throat	☐ Orthopedic	☐ Tuberculosis	

MEDICAL/SURGICAL HISTORY: (procedures, diagnoses, and dates)

Does student require vision correction? ☐ **yes** ☐ **no**
Hearing amplification device? ☐ **yes** ☐ **no**
Preferential seating? ☐ **yes** ☐ **no**

Can student participate in all physical activities? ☐ **yes** ☐ **no**
If not, what are his/her limitations?

Has student had high fever, head injury or period of unconsciousness? ☐ **yes** ☐ **no**
If yes, please give dates and circumstances:

Does student have any pertinent nursing diagnoses? ☐ **yes** ☐ **no**
If yes, please specify:

Does student require skilled nursing care/supervision during the school day? ☐ **yes** ☐ **no**

Does student take medication at home? ☐ **yes** ☐ **no; at school?** ☐ **yes** ☐ **no**
If yes, purpose of medication

Submitted by: **Date:**