

## STUDENTS WITH SPECIAL HEALTH CARE NEEDS SCREENING/REFERRAL CHECKLIST

Student's Name \_\_\_\_\_ School \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

Does the student:	Yes	No	Comments
1. Experience severe allergic reactions that require immediate medications, ie., Epi-Pen?			Describe:
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, respiratory disorders, hemophilia)? Condition: _____			Describe history:
3. Receive medical treatments during or outside The school day (i.e., oxygen, gastrostomy care, tracheostomy care, suctioning, injection)? Condition: _____			
4. Experience frequent absences due to illness or frequent hospitalization?			
5. Receive ongoing medication at home or school for physical or emotional problems (i.e. seizures, heart condition, allergy, asthma, cancer, depression)?			
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 Precautions 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 questions is yes, refer to the school nurse.

Referred To \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_  
(Name of School Nurse)

Referred To \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_