Capistrano Unified School District

San Juan Capistrano, California

HEALTH SUMMARY

Triennial

Student's Last Name _____ First _____ Birthdate _____ Grade _____ Teacher _____ School _____

Address _____ City _____ Phone _____

Person Requesting Information _____ Reason For Request _____

Is student currently under medical care? ___ Yes ___ No Name of Physician _____

Is student on medication? ___ Yes ___ No Name of Medications (s) _____

Current health problems are:

_____

_____

_____

Is student on a special diet? _____

CURRENT TESTING RESULTS

KEY

N - Normal X - Requires Attention R - Referred for Treatment T - Receiving Treatment

HEARING		VISION		WITH GLASSES		COLOR	HEIGHT	WEIGHT
Right	Left	Right	Left	Right	Left	VISION		
		20/	20/	20/	20/			
Date		Date						

Significant past health problems:

_____

_____

_____

_____

Is student currently under the supervision or care of a counselor or outside agency?

Yes___ No___ Explanation if yes: _____

Any past/current referrals for related services and/or designated instructional services?

Yes___ No___ When, Which? _____

Further Recommendations: _____

Date of Developmental History _____

cc: ___ District Special Ed File
___ School Cum
___ Nurse (Health Records)

Report Prepared by: _____ Date: _____

TITLE

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