

Livingston County Special Services Unit

Medical Review Summary Re-evals without Assessment

Date: _____

Student Name: _____

District: _____

DOB: _____

Current Grade: _____

Case Manager: _____

Eligibility: _____

Information Obtained From:

☐ File Review ☐ Domain Review ☐ Parent/Guardian ☐ Medical Records ☐ Other: _____

Notes: _____

HEALTH HISTORY:

• Allergies: _____

• Health Concerns: ☐ Ears ☐ Eyes ☐ Respiratory ☐ Walking ☐ Eating/Feeding
☐ Toileting ☐ Cardiac ☐ Diabetes ☐ Other _____

Please Explain Further: _____

• Medications: ☐ No ☐ Yes

Medication	Dosage	Times Taken Each Day

• Attendance concerns: ☐ No ☐ Yes If yes, number of days missed current school year ____.

• Date of last Vision and Hearing Screening: _____

○ Results: Vision ☐ Pass ☐ Fail ☐ Rescreen
Hearing ☐ Pass ☐ Fail ☐ Rescreen

Signature of Person Completing Form: _____

Please include this form in Evaluation Folder

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SCHOOL NURSE'S STATEMENT OF EDUCATIONALLY RELEVANT MEDICAL CONDITIONS:

☐ None ☐ Yes, Specify:

☐ Additional data should be collected in the area of Health as part of evaluation/re-evaluation.

1.

2.

School Nurse's Signature: _____ Date: _____

Returned to School Social Worker: _____ on _____ (Date)

ADDITIONAL NOTES/INFORMATION FROM THE FRONT: