MUSD Health Services
Health Update

COST _____ SST _____

Date:_____
Student Name: _____ DOB:_____
ID# _____ Grade: _____

Distance Vision: RT: 20/_____ LT: 20/_____ Date: _____
Near Vision RT: 20/_____ LT: 20/_____

Hearing: RT: pass _____ fail _____ Date: _____
LT: pass _____ fail: _____

Is student on any medication at school: yes _____ no _____

Medication: _____ Reason: _____
Medication: _____ Reason: _____

Any Confidential Health Issues/Nurse Concerns:
_____
_____
_____

SST MEETING (Information Shared By Parent)

Student Issue: _____
Parent Concern: _____
Medications at Home: _____
Chronic Health Issues: _____
Information Shared by Parent:
_____
_____
_____
_____

Follow-up SST Meeting

Health information will be shared at follow-up SST meeting: _____
_____
_____
_____
_____