RIVERSIDE UNIFIED SCHOOL DISTRICT

Health Services Request Form 26-9580

Phone 951-274-4213 x 83075 Fax 951-274-4200 x 83100

Requestor please complete top portion completely

CONFIDENTIAL INFORMATION ☐ **New Student** SCHOOL_____ DATE_____

NAME OF STUDENT _____STUDENT # _____GRADE_____

TEACHER _____ROOM # _____RM. TEL. # _____DOB_____

PARENT _____HOME PHONE _____

HOME ADDRESS _____

CELL PHONE _____ WORK PHONE _____

REQUESTED BY_____TITLE _____EXT_____

SERVICES REQUESTED: ☐CONCERN ☐DISABILTY_____

☐ **IEP DATE** _____VISION: FAR☐ NEAR☐ HEARING☐

☐ **Aeries Checked- Date of last screening: _____** ☐**No Results**

☐**Initial Assessment** ☐ **3-Year Assessment**

FOR DISTRICT NURSE USE ONLY: DATE REQUEST COMPLETED_____

VISION RESULTS: *PASS/FAIL RIGHT EYE 20/_____ LEFT EYE 20/_____* ☐ With Correction ☐ Glasses Broken/Lost/At home

NEAR POINT: *PASS/FAIL RIGHT EYE 20/_____ LEFT EYE 20/_____*

HEARING RESULTS: *PASS/FAIL* ***RIGHT EAR*** ☐*500*☐*1K*☐*2K*☐*4K* ***LEFT EAR*** ☐*500*☐*1K*☐*2K*☐*4K*
☐ *OAE* ***RIGHT EAR*** ☐ *REFER* ***LEFT EAR*** ☐ *REFER*

DATE RETESTED _____ HEARING RESULTS: *PASS/FAIL*

	250	***500***	***1K***	***2K***	***4K***	***8K***
Right						
Left						

For District Nurse Use Only

Date _____Findings/Observations _____

_____

_____

Date of Referral _____Reason _____

Referred to _____

☐Home Contact Type: ☐Telephone ☐In Person ☐Written ☐ Other _____ Date _____

Spoke to: _____ Relationship to Student _____

Result/Outcome _____

_____

SIGNATURE OF NURSE _____DATE _____

☐Entered into Aeries ☐ Entered into SBR

Results sent to ☐ Teacher ☐ RSP ☐ SLP ☐ Other _____