Student Assistance Program
STUDENT INFORMATION FORM
NURSE

Please return to: SAP Coordinator

Student's Name_____ Date_____

Homeroom Teacher_____ Grade_____

Vision: In normal range? _____Yes _____No
Follow-up by Family Dr. _____Yes _____No
Comments:_____

Hearing: In normal range? _____Yes _____No
Follow-up by Family Dr. _____Yes _____No
Comments:_____

Current medications:_____
_____

Known Allergies:_____
_____

Does this child make frequent visits to the nurse/office? _____Yes _____No
Please explain:_____
_____

Medical conditions and/or history that may impact school work, behavior, or attendance:_____
_____
_____

Nurse's Signature: _____ Date: _____