



Guam Department of Education  
Form H: Child Study Team I General Health Information

**FORM TO BE COMPLETED BY:** School Administrator or Designee

(Revised 01/08/2026)

Date Completed:

Student:	Student #:
----------	------------

The information shall be completed by the *School Health Counselor or designee* and forwarded to the Child Study Team for review and to assist the team on what additional data, if any, is needed.

**School Health Counselor Name:**

Health & Date Exam/Screening	Type/Description of Data Reviewed	Summary of Information
<input type="checkbox"/> Physical Examination Date:		
<input type="checkbox"/> Vision screening/evaluation Date:		<input type="checkbox"/> Passed <input type="checkbox"/> Failed Lt. Acuity Rt. Acuity Wears glasses: <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Hearing screening/evaluation Date:		Tympanogram <input type="checkbox"/> Passed <input type="checkbox"/> Failed Pure Tone <input type="checkbox"/> Passed <input type="checkbox"/> Failed
<input type="checkbox"/> School Health Records Date:		Does the student have an IHP? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other screening/evaluation Date:		
<input type="checkbox"/> Other screening/evaluation Date:		

Other medical information (diagnosis, medication, immunization record, etc.) considered or reviewed: