"Insert School Name"

OFFICE OF THE SCHOOL NURSE

SCHOOL HEALTH SERVICES SUMARY

DATE: _____
Time Covered: Day ____ Week ____ Month ____ Quarter ____ Year ____

I. Health Supervision	**Number**	**Time spent (minutes)**
A. Injured:	_____	_____
Ill	_____	_____
B. Health Consulting:	_____	_____
C. Special Procedures:	_____	_____
D. Child Abuse:	_____	_____
E. Medications:		
Initial Instruction	_____	_____
Administration	_____	_____
Monitoring	_____	_____
F. Medical referrals:		
a. ADHD		
Initial Referral	_____	_____
Follow Up	_____	_____
b. Asthma		
Initial Referral	_____	_____
Follow Up	_____	_____
c. Medical		
Initial Referral	_____	_____
Follow Up	_____	_____

G. Records:	**#Reviewed**	**#Recorded Time (mins)**
Incoming	_____	_____
Outgoing	_____	_____
CSC	_____	_____
Medical	_____	_____
H. Health Conditions:		
Update	_____	_____
Notes	_____	_____
Calls	_____	_____

II. SCREENINGS:	**#Referred**	**#Recorded**	**#Returned**	**Time (mins)**
Vision	_____	_____	_____	_____
Hearing	_____	_____	_____	_____
Ht. & Wt.	_____	_____	_____	_____
Blood Pressure	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Immunizations	_____	_____	_____	_____
Scalp/Skin	_____	_____	_____	_____
Spinal	_____	_____	_____	_____
Communicable	_____	_____	_____	_____
Disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

III. HEALTH EDUCATION ACTIVITIES:

	#Student	**#Class**	**#Parent**	**#Staff**	**#Community**
A. Planning	_____	_____	_____	_____	_____
B. Presenting	_____	_____	_____	_____	_____

IV. MEETINGS ATTENDED: **Number** **Time spent (minutes)**

A. School

Student Support Team	_____	_____
Child Study Committee	_____	_____
Crisis Intervention Team	_____	_____
Faculty	_____	_____
Wellness	_____	_____
Other	_____	_____

B. Community

Community Red Cross	_____	_____
Health & Wellness	_____	_____

C. District

Pupil Personnel Services	_____	_____
Nursing	_____	_____

D. Other Activities **Total** **Time Spent (minutes)**