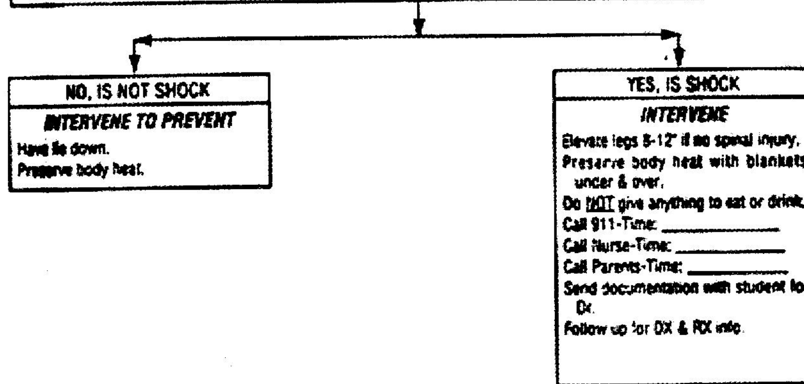
# SHOCK

**Record assessments & interventions by circling Yes, No, & intervention done, plus filling in blanks.**

***ASSESS SIGNS & SYMPTOMS***

Rapid Breathing? YES NO
Rapid/weak pulse? YES NO
Decreased BP? YES NO
Restless or irritable? YES NO
Pale/bluish, cool, moist skin? YES NO
Slow capillary filling time? YES NO
Heavy sweating? YES NO
Dilated pupils? YES NO
Dull, sunken look to eyes? YES NO
Excessive thirst? YES NO
Nausea/vomiting? YES NO
Drowsiness/loss of consciousness? YES NO

| Time | | | | | | | |
|---|---|---|---|---|---|---|---|
| R | | | | | | | |
| P | | | | | | | |
| BP | | | | | | | |



NO, IS NOT SHOCK

***INTERVENE TO PREVENT***

Have lie down.
Preserve body heat.

YES, IS SHOCK

***INTERVENE***

Elevate legs 8-12" if no spinal injury.
Preserve body heat with blankets under & over.
Do NOT give anything to eat or drink.
Call 911-Time: ____________
Call Nurse-Time: ____________
Call Parents-Time: ____________
Send documentation with student for Dr.
Follow up for DX & RX info.

NURSE: ______________________________ SCHOOL: ______________________

ADDRESS: ________________________________ PHONE: ______________

**PHYSICIAN'S REPORT:**
Please write diagnosis and treatment and return to school nurse. Include any accomodations that will be required at school.

______________________________
Physician's Signature