**School:**

**Student Name:**

**Date of Birth:**

# Nursing Assessment

## The following sources of information were used to complete this assessment:

Student observation

Date/Results:

Information from community, agency, staff, or other

Source/Date:

Review of school records

Date:

Review of medical records

Source/Date:

Interview

Source/Date:

## Health Examinations and Screening Results

Physical

Date/Examiner/Results:

Vision

Date/Examiner/Results:

Hearing

Date/Examiner/Results:

Educationally Relevant Past Medical and Developmental History:

## Current Health Status

Medical Diagnoses:

Medications:

Student Health Needs During the School Day:

# Individual Health Plan

|  |  |  |
| --- | --- | --- |
| Parent/Guardian: | Preferred Phone #1: | Preferred Phone #2: |
| Primary Care Provider: | Release Date: | Phone: |
| Specialist(s): | Release Date: | Phone: |

IHP Date:

## Emergency Action Plan

Yes

No

## Emergency Evacuation Plan

Yes

No

IEP/504 Date:

ICD-10 Codes:

IHP Written By:

| Nursing Diagnosis | Intervention | Expected Outcome |
| --- | --- | --- |
|  |  |  |

# Evaluation

| Date/Time In/Time Out | Progress Note | Electronic Signature |
| --- | --- | --- |
|  |  |  |

| Date/Time In/Time Out | Progress Note | Electronic Signature |
| --- | --- | --- |
|  |  |  |

| Date/Time In/Time Out | Progress Note | Electronic Signature |
| --- | --- | --- |
|  |  |  |

| Date/Time In/Time Out | Progress Note | Electronic Signature |
| --- | --- | --- |
|  |  |  |

| Date/Time In/Time Out | Progress Note | Electronic Signature |
| --- | --- | --- |
|  |  |  |