

# Example of Form

# Access in SEAS

Date of Report \_\_\_\_\_

	Phone: _____ Fax: _____
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- Initial Evaluation
- Re-Evaluation
- Special Request by ARD Committee

## EVALUATION REPORT: SCHOOL HEALTH SERVICES

Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Student #: \_\_\_\_\_ Campus: \_\_\_\_\_ Grade: \_\_\_\_\_

**PROFESSIONAL EVALUATOR:** School Nurse/Licensed Health Professional

SOURCE OF DATA	DATE	SOURCE OF DATA	DATE
Full and Individual Evaluation Report			
Information from Licensed Physician (Order or Prescription)			

## NAME OF PHYSICIAN RECOMMENDING, ORDERING, OR PRESCRIBING HEALTH SERVICES

**DIAGNOSTIC IMPRESSION:** \_\_\_\_\_

### LEARNING COMPETENCIES:

- Good general health
- Documented  hearing loss  vision loss
- Fine Motor Skills are  appropriate  delayed
- Gross Motor Skills are  appropriate  delayed
- Difficulty maintaining attention
- Uses Mobility Aids  walker  wheelchair
- Wears  hearing aids  corrective lenses
- Student is medically fragile
- Requires special health procedure  catheterization  suctioning  gastrostomy feeding  toileting
- activities of daily living  \_\_\_\_\_

### SPECIFIC HEALTH SERVICES REQUIRED:

- Dispensing of Prescribed Medication in School
  - Medication: \_\_\_\_\_ When Given? \_\_\_\_\_
  - Medication: \_\_\_\_\_ When Given? \_\_\_\_\_
- Training and Supervision of Health Procedures related to:
  - catheterization  gastrostomy feeding  tracheostomy monitoring  suctioning  seizures
  - \_\_\_\_\_
- Monitoring Equipment/Environmental Needs
  - wheelchair  braces  hearing aids  heat/coolness of environment  \_\_\_\_\_
- Monitoring:  special diet  rest periods  positioning  \_\_\_\_\_
- Periodic Assessment of Medical Condition in Instructional Setting
- Screening and Referral for Health Needs
- Consultation with the Physician and parents regarding the effects of medication
- Counseling with students and their families concerning health care practices and services
- Training in Emergency Care for Staff and/or Parents

**SERVICE RECOMMENDATIONS:** Based on the information reported, it is the professional opinion of the school nurse/licensed health professional that this student  needs  does not need the provision or supervision of the indicated School Health Services by an RN, LVN or Delegated Nursing Services Provider in the school setting, in order to receive education benefit from his/her special education.

Amount of Time: \_\_\_\_\_ Frequency:  daily  weekly  monthly  \_\_\_\_\_  
 Duration of Service: \_\_\_\_\_

- An ARD committee made up of a group of qualified professionals and the parent of the student will complete final determination of eligibility for special education based upon disability and educational need(s).

\_\_\_\_\_  
Signature of School Nurse/Licensed Health Professional

\_\_\_\_\_  
Date of Report