**Nursing and School Health Aide Services Treatment Form**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Last Name | | | Doe | | | MI | | |  | First Name | | | Jane | | | DOB | | 3/10/1997 | Date | XX-XX-20XX |
| Student ID | 123456789 | | | Gender | F | |  | | | | District | Anaheim | | | School | | Disney | | | |
| Health Condition | | Seizures, Diabetes | | | | | | IEP  IFSP | | | | | | Date of Most Recent Nursing Plan: XX-XX-20XX | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Instructions:** Document actual clock time spent with individual student performing MD-prescribed service(s) in nursing plan. See most recent Nursing Plan for usual symptoms, seizure pattern (if any), treatment plan, medications, protocols and emergency contacts. Do not report more than one student at the same time. Treatment services are billed to Medi-Cal in 15-minute increments. One unit of service may be billed if a minimum of 7 or more continuous minutes of direct service time is provided to a student. A unit cannot be made up of shorter time periods provided throughout the day and added together. The “units” column below refers to the number of billable units of service, and may need to be computed by billing/fiscal personnel.  ***Draw a horizontal line in the cells below to document actual clock time spent with student performing service in nursing plan.*** | | | | | | | | | | | | | |
| **TIME** | **:00-**  **:07** | **:08-**  **:14** | **:15-**  **:24** | **:23-**  **:29** | **:30-**  **:37** | **:38-**  **:44** | **:45-**  **:53** | **:53-**  **:60** | **Total Minutes** | **Units** | **Observations / Concerns \*** | **Procedures / Interventions / Medications Given \*** | **Initials** |
| 7:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9:00  am |  |  |  |  |  | SAMPLE |  |  |  |  |  |  |  |
| 10:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11:00  am |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4:00  pm |  |  |  |  |  |  |  |  |  |  |  |  |  |

\*\* The tables of observations and procedures are to be customized by the

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| --- | --- | --- | --- | --- |
| \* Attach separate Progress Notes page if more space is needed to describe any changes, events or concerns.  By signing below, I certify that I have been trained by the school nurse to observe, monitor and provide health-related interventions for this student. | | | |  |
| **Printed Name** | **Initials** | **Auth. Title** | **Signature** | **Date** |
|  |  | THCA, LVN, RN, or SCIA-THCA |  |  |
|  |  | THCA, LVN, RN, or SCIA-THCA |  |  |
| By signing below, I certify that the above person(s) has been trained to observe, monitor and provide health related interventions for this student. | | | |  |
| **Printed Name** | **Initials** | **Auth. Title** | **Signature** | **Date** |
|  |  | Registered Credentialed School Nurse |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Observations / Concerns \*\*** | |  | **Procedures / Interventions \*\*** | |
| A | Alert/Attentive/Involved |  | BGT | Blood Glucose Testing |
| AM | Abnormal Movements (specify) |  | CC | Carb Count |
| C | Comfortable/Cooperative |  | IA | Insulin Administration |
| D | Distracted/Restless |  | M | Medication |
| E | Emotional/Crying |  | MA | Mobility Assistance |
| S | Sick fever, vomiting, cramps, etc. |  | MFI | Monitor Fluid Intake |
| SK | Skin color pail or blue |  | O | Other (specify) |
| SZ | Seizure |  | R | Reposition |
| T | Tired/Sleepy |  | SBS | Stand by for Safety |
| U | Uncooperative/Upset/Angry |  | SX | Suctioning |
| W | Wheezing, Coughing, Short of Breath |  | TF | Tube Feeding |

credentialed school nurse to reflect the needs of an individual student.