

Carroll County Public Schools – Impairment Assessment

Name of Student:		Date of Birth:		Gender:	
School:		Grade:		Referred By:	

ASSESSMENT

Accompanied By:		Date:		Start Time:	
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REASON FOR ASSESSMENT

Current Medication(s) – OTC & Prescribed	Last Dose Taken

PHYSICAL FINDINGS

Vital Signs:	Blood Pressure _____	Pulse _____	Respiration _____	Temperature _____
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LEVEL OF CONSCIOUSNESS

Oriented to time, place, person:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Short term memory intact:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

BEHAVIOR FINDINGS

Activity level (check all that apply)

Confused
 Hyperactive
 Irritable
 Restless
 Slow
 Uncooperative
 Normal

SPEECH (check all that apply)

Incoherent
 Rambling
 Slurred
 Normal

ANY PHYSICAL COMPLAINTS REPORTED BY STUDENT?

Check: <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, please describe: Last time student has something to eat: _____
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EYE INDICATORS (Per NHTSA. Significant psychomotor impaired evident with four (4) or more positive findings.)

Eyes (check all that apply)	RIGHT	LEFT	Sclera:	RIGHT	LEFT
Reaction to Light:	Reactive		Sclera:	Normal	
	Slow			Bloodshot	
	No Reaction			Watery	
Pupil Size:	Normal				
	Constricted				
	Dilated				

ADDITIONAL PHYSICAL SIGNS (check all that apply)

Runny Nose
 Bloody Nose
 Pale
 Tremors
 Flushed
 Vomiting
 Sweating
 Other(explain)

Explain (Other): _____

DID STUDENT REPORT ANY SUBSTANCE USE?

<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list name of substance(s), when used, amount used, route used:
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ANY ODOR DETECTED ON STUDENT?

Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hands	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hair	<input type="checkbox"/> YES <input type="checkbox"/> NO	Clothing	<input type="checkbox"/> YES <input type="checkbox"/> NO
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If YES, please describe: _____

COMMENTS

Administrator Notified / Received Completed Assessment:	
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Signature of Nurse

Time Completed