Carroll County Public Schools - Health Services - Monthly Report

School: ____ Month/Year: __________________________ School Enrollment: __________

Total Number Seen: _________________ Person Completing Report: ____

*** Do not include fluoride in total # seen.**

I. Health Room Visits - Students

A.) Illness - Acute ______
Illness - Chronic ______
Reproductive/Pregnancy Health ______
Injury - Minor ______
Injury - Serious ______
Injury - Intentional ______
Previously Sustained Injury ______
Mental Health ______
Substance Abuse ______
Headlice ______
Dental ______
Miscellaneous ______
Total of (A.) ______

B.) Students Sent Home ______
(include ill/injured)
Students Sent to MD/ER ______
Students Sent 911 ______
Total of (B.) ______

C.) Staff Health
Treatment ______
Ill ______
Injured ______
Sent 911 ______
Total of (C.) ______

D.) Community Health
Treatment ______
Ill ______
Injured ______
Sent 911 ______
Total of (D.) ______

II. Treatment/Medication

A.) Peak Flow Meters ______
Glucose/Ketone ______
B/P - Student ______
Tube Feedings ______
Neuro Checks ______
Oro-Pharyngeal Suction ______
Restraint Check ______
Catheterization ______
Nebulizer ______
IV Therapy/Site Monitoring ______
Other *(list)* ______________________ ______
_________________________ ______
Total of (A.) ______

B.) Daily Meds Logged in SASI ______
PRN Meds Logged in SASI ______
Total of (B.) ______

C.) Daily Meds *Not* Logged in SASI ______
PRN Meds *Not* Logged in SASI ______
Total of (C.) ______
****(Add total of C in Total Students Seen)***

D.) Fluoride ______

Total Medications *(Total of B, C & D)* ______

III. Record Keeping

Health Records Reviewed/Prepped ______
Field Trip/Outdoor School Prep ______
Accident/Serious Illness/Head Injury Reports Completed ______
Emergency Procedure Sheets Sent ______
Nursing Care Plans Completed/In Progress ______
Monthly Medication Count ______
Other:_________________________________ ______

Screenings:
Hearing ______ - ______Follow-up
Vision ______ - ______Follow-up
TOTAL ______ - ______

Out of Compliance for:
Immunization ______
Health Inventory ______
Lead Testing ______
Communicable Diseases Reported ______
**(Attach Communicable Disease Report)*
Total ______

IV. Referrals

CCHD ______
DSS ______
Support Room ______
Crisis/Guidance ______
Parent Contacts ______
PPW/SST ______
SAP/SAT ______
Administration ______
Total ______

V. Meetings/Conferences - attended/given

Meetings
Faculty ______
SST ______
IEP/504
Transition/SAP ______
CHN - Routine Visits/Contacts ______
Parent Education ______

Health Education
Individual – Student ______
Group - Student ______
Individual - Staff ______
Group - Staff ______
Community Programs ______
Community Contact ______

Conference/Consult
Staff ______
Parent/Student ______
DDS/MD/TELE ______

Continuing Education
Staff In-Service ______
Outside Workshops ______
Total ______

VI. Health Management

A.) *Intra-Agency Contacts*
Supervisor of Health Services ______
Insurance Risk Manager ______
Secretary of Health Services ______
Secretary of Guidance ______
School Nurse ______

B.) *Inter-Agency Contacts*
Junction ______
CCHD ______
YSB ______
Day Care Centers ______
Other ______
Total of A & B ______