LOS ANGELES UNIFIED SCHOOL DISTRICT
SPECIAL PHYSICAL HEALTH CARE SERVICES

School:	District:	Phone: ( )	Ext:	School Nurse:

STUDENTS WITH DIABETES (***** Enter diagnosis in Welligent)

Name	Birthdate	Gr/Trk	Blood Glucose Testing Schedule	Carb Count	Insulin Daily	Insulin Correction	Pump	Pen	Syringe	Glucagon	Procedure performed by
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		

School personnel training date: _____

____Number of students with diagnosed Asthma

____Number of students who self-carry asthma

____Number of students with Asthma Action Plans from Health Care Provider

____Number of students on Quick Relief/Rescue Inhalers @ school

STUDENTS WITH ASTHMA needing Mechanical Nebulizer (not inhalers) (***** Enter diagnosis in Welligent)

Name		Birthdate	Gr/Trk	Mechanical Nebulizer Treatment At School
				Medication: Time or ☐ PRN
				Medication: Time or ☐ PRN

School personnel training date: _____

STUDENTS WITH SEVERE ALLERGY – needing the Epinephrine Auto Injector (* Enter diagnosis in Welligent)

Name		Birthdate	Gr/Trk	
				Auto Injector: Severe allergy to
				Auto Injector: Severe allergy to

School personnel training date: _____

- **This form is due by Friday, August 26, 2022 to your Local District Nursing Office**
- **Notify your Local District Nursing Office immediately of additions or changes as they occur during the school year.**
- **Place a copy of this form in the School Nurse Substitute Folder.**

SPECIAL PHYSICAL HEALTH CARE SERVICES (Special Procedures)

DO NOT include Asthma/Allergy or Diabetic procedures listed on front of form

(* Enter diagnosis in Welligent)

School: ____________________ **School Nurse** ____________________

Are there other Licensed Health Care Providers (LVN/RN) on your campus? ☐NO ☐YES _____Number	_____Number of Health Care Assistants

Name	Birthdate	Gr/Trk	Special Procedure	Time	Procedure performed by:
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision
					☐ RN ☐ LVN ☐ HCA ☐ Other __________ ☐ Student ☐ Student with supervision

_____**Number of students diagnosed with Seizure Disorder** (* Enter diagnosis in Welligent)

STUDENTS WITH SEVERE SEIZURES with a Diastat order

Name	Birthdate	Gr/Trk	Name	Birthdate	Gr/Trk

Notify your Nursing Coordinator immediately of additions or changes as they occur during the school year by updating and resubmitting this form

*** ALL STUDENT DIAGNOSIS MUST BE ENTERED INTO WELLIGENT**