Form 33.19
Rev. 7/03

LOS ANGELES UNIFIED SCHOOL DISTRICT
Nursing Services

☐ Initial ☐Annual ☐3Yr.
☐Other:

IEP/IFSP School Nurse Health Assessment

Student Name: , . Birthdate: Age: ☐male ☐female

School: Grade: Room: Track: LEARN Spec. Ed. Eligibility (if applicable)

Current Informant(s): Relationship: Date:

Home Language: Translator's name if applicable:

A) DEVELOPMENTAL HISTORY (For Initial Assessment Only)

1) Prenatal history: ☐Full Term ☐Premature weeks Birth weight lbs. oz. Delivery: ☐Vaginal ☐C-section

2) Birth Place: Born at: ☐ Hospital ☐ Other: Home with Mother: ☐Yes ☐No

3) List Prenatal/Birth/ Newborn Complications:

4) Milestones: Sat Alone Months Crawled Months Walked Months First Word(s) Months Sentences Months
Toilet Trained (days) (age) Toilet Trained (nights) (age)

5) Comments:

B) HEALTH HISTORY

1) Health history obtained by: ☐Interview with Parent/Guardian ☐Medical Report ☐Review of school health record ☐Other:

2) Name of Health Care Provider (if applicable):

3) Current diagnosis (if applicable):

4) Current medication(s) include time and dosage:

5) Current protocol(s):

6) Significant family health history (if applicable): ☐No ☐Yes, summarize:

7) Parent areas of concern: ☐Academic ☐Behavior at Home/School ☐Physical Health ☐Development ☐Social/Peer Relationships

8) Summarize/update health history (include serious/ chronic illness, allergies, injury, accident, surgery, hospitalization, counseling, or psychiatric care):

9) Additional information including outside services, previous screenings and developmental update (if applicable):

C) HEALTH ASSESSMENT

1) Date: Height: inches, % Weight: lbs., % Blood Pressure: /

2) Date: Vision: Without Correction: R 20/ L 20/ Both 20/ Referred:
With Correction: R 20/ L 20/ Both 20/ Referred:

3) Date: Audio: ☐Yes ☐No Passed/Failed: Referred:

4) Activities of daily living (ADL): ☐Independent ☐Needs assistance (Include toileting, feeding, use of hands and arms)
Summarize:

5) Mobility: ☐No assistance needed ☐ Leg braces ☐ Walker/crutches ☐Wheel chair with assistance ☐Wheel chair without assistance

6) Additional referral(s):

7) Comments:

Completed by: Signature: _____ Date:

SCHOOL NURSE HEALTH ASSESSMENT (Continued)

School _____

Student Name _____ Birth date _____ Date _____