LOS ANGELES UNIFIED SCHOOL DISTRICT
Nursing Protocol Log

Please Print

STUDENT NAME: LAST _____ **FIRST** _____

STUDENT ID _____ **DOB** ____/____/____ (MM DD YY) **AUTHORIZED BY:** ☐ **IEP** ☐ **504** ☐ **N/A**

SCHOOL NAME _____ **LOCATION CODE** _____ **DIAGNOSIS CODE** _____

CREDENTIALED SCHOOL NURSE NAME _____ **EMPLOYEE NUMBER** _____

The signature of the service provider certifies under penalty of perjury that the information contained on this form is true and correct.

CREDENTIALED SCHOOL NURSE SIGNATURE _____ **DATE:** _____

Procedure

Authorizing Licensed Healthcare Provider: _____ Telephone Number _____

1. Print Name, title: Empl. #		Signature:	Initials:	Date:
2. Print Name, title: Empl. #		Signature:	Initials:	Date:
3. Print Name, title: Empl. #		Signature:	Initials:	Date:
4. Print Name, title: Empl. #		Signature:	Initials:	Date:
5. Print Name, title: Empl. #		Signature:	Initials:	Date:

Date	Time In	Time Out	Comments	Initials

Date	Time In	Time Out	Comments	Initials