

Office of the Chief Medical Director

District Nursing Services

REVIEW FOR SUPPORT SERVICES DUE TO HEALTH NEEDS

*SCHOOL NURSE COMPLETES THIS FORM IN COLLABORATION WITH THE SITE ADMINISTRATOR 30 DAYS **PRIOR** TO THE IEP MEETING*

Initial

Continuing

Student Name		Student ID	
School	Phone	Fax	
Grade	<input type="checkbox"/> General Ed Class	<input type="checkbox"/> Special Ed Class	
School Nurse	Request Date	IEP Date	
Health needs requiring support:			
Does the student's condition require continuous monitoring and supervision by DAQP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe specific needs.			

Check the specialized physical health care procedures that the student requires:

- | | |
|--|--|
| <input type="checkbox"/> Gastrostomy Tube Feeding | <input type="checkbox"/> Gastrostomy Replacement |
| <input type="checkbox"/> Jejunostomy Tube Feeding | <input type="checkbox"/> Oxygen Therapy |
| <input type="checkbox"/> Oral/Nasal Suctioning | <input type="checkbox"/> Oropharyngeal/Nasopharyngeal Suctioning |
| <input type="checkbox"/> Tracheostomy Suctioning and Replacement | <input type="checkbox"/> Autonomic Dysreflexia |
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> Other _____ |

The student requires services from a Licensed Nursing Provider for the following reason:

School Nurse: Please fax this form to District Nursing Services at (213) 580-6557. If a need becomes known during the IEP meeting, call District Nursing Services for consultation at (213) 202-7580.

District Nursing Services (DNS) Review:

DNS Signature _____ Date _____