

**LOS ANGELES UNIFIED SCHOOL DISTRICT
SPECIAL PHYSICAL HEALTH CARE SERVICES**

School:	District:	Phone: ()	Ext:	School Nurse:
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<u>STUDENTS WITH DIABETES</u> (* 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
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

School personnel training date: _____

_____ Number of students with diagnosed Asthma		_____ Number of students with Asthma Action Plans from Health Care Provider
_____ Number of students who self-carry asthma		_____ Number of students on Quick Relief/Rescue Inhalers @ school

<u>STUDENTS WITH ASTHMA needing Mechanical Nebulizer (not inhalers)</u> (* Enter diagnosis in Welligent)					
Name	Birthdate	Gr/Trk	Mechanical Nebulizer Treatment At School		
			Medication:	Time	or <input type="checkbox"/> PRN
			Medication:	Time	or <input type="checkbox"/> PRN

School personnel training date: _____

<u>STUDENTS WITH SEVERE ALLERGY – needing the Epinephrine Auto Injector</u> (* 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 **Tuesday, August 22, 2023** to your Region Nursing Office
- Notify your Region 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)

2023/2024

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:
					<input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> HCA <input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Student with supervision
					<input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> HCA <input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Student with supervision
					<input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> HCA <input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Student with supervision
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					<input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> HCA <input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Student with supervision
					<input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> HCA <input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> 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**