School District Of Philadelphia
School Health Services
Nursing Assessment Tool

Name: _____ Gender: M/F DOB: _____
Parent/Guardian Name: _____
Address: _____ Zip code: _____
Home Phone: _____ cell: _____ work: _____
Emergency Contacts
1. Name:_____ Phone: _____
2. Name:_____ Phone: _____
Primary Care Provider: _____ Phone: _____
Specialist Provider: _____ Phone: _____
Diagnoses: _____
Allergies: food_____drug: _____Immunizations complete: yes/no
Current Medications:
Drug Name: _____ Dosage: _____ Route: _____ Time:_____
Drug Name: _____ Dosage: _____ Route: _____ Time:_____
Drug Name: _____ Dosage: _____ Route: _____ Time:_____
Medication/treatments during school: yes/no explain _____
Communication: _____
Primary language_____ Able to speak: yes/no_____
Vision: _____ Hearing: _____
OTHER: _____
Review of Systems:
Neurological: _____
seizures yes/no type of seizures: _____ date of last seizure: _____
how long do seizures last: _____ Diastat RX: _____
Helmet yes/no OTHER:_____
Respiratory: _____
Tracheostomy yes/no suction needed yes/no supplemental oxygen yes/no
OTHER:_____
Cardiovascular: _____activity resriction: yes/no:_____
Intravenous Line/s yes/no type: _____
OTHER: _____
Gastrointestinal: _____
G tube yes/no type : _____ **feeding needs**: Via tube/bolus/drip/pump yes/no
Dietary restrictions: _____ Feeding assistance needed: _____
Genitourinary: _____
Catheterization: _____
Toileting needs: _____ Diapering needs yes/no
OTHER: _____
Musculoskeletal: _____
Mobility: ambulatory/wheelchair/walker/crutches yes/no_____
Accessibility: _____
Physical transferring needs: _____
Protective Equipment needs: _____
Integumentary: _____
decub/excoriation yes/no wound care yes/no
OTHER: _____
E. I. Services received: OT yes/no PT yes/no Speech yes/no
Private Duty Nurse yes/no Medical transportation yes/no
Signature of Nurse performing the assessment: _____**Date**: _____
M-159 3/08