Nursing and School Health Aide Services Treatment Form

Student's Last Name Doe MI ___ First Name Jane DOB 3/10/1997 Date XX-XX-20XX

Student ID 123456789 Gender F District Anaheim School Disney

Health Condition Seizures, Diabetes ☒ IEP ☐ IFSP Date of Most Recent Nursing Plan: XX-XX-20XX

Instructions: Document actual clock time spent with individual student performing MD-prescribed service(s) in nursing plan. See most recent Nursing Plan for usual symptoms, seizure pattern (if any), treatment plan, medications, protocols and emergency contacts. Do not report more than one student at the same time. Treatment services are billed to Medi-Cal in 15-minute increments. One unit of service may be billed if a minimum of 7 or more continuous minutes of direct service time is provided to a student. A unit cannot be made up of shorter time periods provided throughout the day and added together. The "units" column below refers to the number of billable units of service, and may need to be computed by billing/fiscal personnel.
Draw a horizontal line in the cells below to document actual clock time spent with student performing service in nursing plan.

TIME	:00-:07	:08-:14	:15-:24	:23-:29	:30-:37	:38-:44	:45-:53	:53-:60	Total Minutes		Procedures / Interventions / Medications Given *	Initials
7:00 am												
8:00 am												
9:00 am												
10:00 am												
11:00 am												
12:00 pm												
1:00 pm												
2:00 pm												
3:00 pm												
4:00 pm												

Insert student information here

Insert student condition(s) here

Insert date of most recent Student Nursing Plan here

If additional space is required, use separate progress log and attach to this page

Amend legend based on student's health condition, needs, interventions, etc.

Supervising practitioner

Observations / Concerns **	
A	Alert/Attentive/Involved
AM	Abnormal Movements (specify)
C	Comfortable/Cooperative
D	Distracted/Restless
E	Emotional/Crying
S	Sick fever, vomiting, cramps, etc.
SK	Skin color pail or blue
SZ	Seizure
T	Tired/Sleepy
U	Uncooperative/Upset/Angry
W	Wheezing, Coughing, Short of Breath

Procedures / Interventions **	
BGT	Blood Glucose Testing
CC	Carb Count
IA	Insulin Administration
M	Medication
MA	Mobility Assistance
MFI	Monitor Fluid Intake
O	Other (specify)
R	Reposition
SBS	Stand by for Safety
SX	Suctioning
TF	Tube Feeding

** The tables of observations and procedures are to be customized by the credentialed school nurse to reflect the needs of an individual student.

* Attach separate Progress Notes page if more space is needed to describe any changes, events or concerns.

By signing below, I certify that I have been trained by the school nurse to observe, monitor and provide health-related interventions for this student.

Printed Name	Initials	Auth. Title	Signature	Date
		THCA, LVN, RN, or SCIA-THCA		
		THCA, LVN, RN, or SCIA-THCA		

By signing below, I certify that the above person(s) has been trained to observe, monitor and provide health related interventions for this student.

Printed Name	Initials	Auth. Title	Signature	Date
		Registered Credentialed School Nurse		

For a visual representation of the Nursing and School Health Aide Services Treatment Form and instructions please see below.

Insert student information below.

Student's Last Name

Middle Initial

First Name

Date of Birth

Date

Student Identification

Gender

District

School

Insert student condition(s) below.

Health Condition

Individualized Education Plan

Individualized Family Service Plan

Insert date of most recent nursing plan.

Instructions: Document actual clock time spent with individual student performing MD-prescribed service(s) in nursing plan. See most recent Nursing Plan for usual symptoms, seizure pattern (if any), treatment plan, medications, protocols and emergency contacts. Do not report more than one student at the same time. Treatment services are billed to Medi-Cal in 15-minute increments. One unit of service may be billed if a minimum of 7 or more continuous minutes of direct service time is provided to a student. A unit cannot be made up of shorter time periods provided throughout the day and added together. The "units" column below refers to the number of billable units of service, and may need to be computed by billing/fiscal personnel.

Draw a horizontal line in the cells of the chart documenting actual clock time spent with the student performing services in a nursing plan. The chart is separated in rows by hours from 7:00 a.m. to 4:00 p.m. and is separated in columns by 7-minute increments, resulting in total minutes, and in units.

There is also a column for observations and concerns, and a column for procedures, interventions and medications given. **If additional space is required, a separate progress log may be attached for both of the previously mentioned columns.** The final column is for the initials of the practitioner.

A table of observations and concerns and a table of procedures and interventions may be customized by the credentialed school based on the student's health condition, needs, interventions, etc.

A sample table for Observations and Concerns follows, and includes the appropriate abbreviations:

A	Alert, Attentive, Involved
AM	Abnormal Movements (specify)
C	Comfortable, Cooperative
D	Distracted, Restless
E	Emotional, Crying
S	Sick, Fever, Vomiting, Cramps, Etc.
SK	Skin color pale or blue
SZ	Seizure
T	Tired, Sleepy
U	Uncooperative, Upset, Angry
W	Wheezing, Coughing, Short of Breath

A sample table for Procedures and Interventions follows, and includes the appropriate abbreviations:

BGT	Blood Glucose Testing
CC	Carb Count
IA	Insulin Administration
M	Medication
MA	Mobility Assistance
MFI	Monitor Fluid Intake
O	Other (specify)

R Reposition

SBS Stand by for Safety

SX Suctioning

TF Tube Feeding

By signing below, I certify that I have been trained by the school health nurse to observe, monitor and provide health-related interventions for this student.

Printed Name

Initials

Authorized Title: For example, THCA, LVN, RN or SCIA-THCA

Signature

Date

By signing below, I certify that the above person(s) has been trained to observe, monitor and provide health related interventions for this student.

Printed Name of the Supervising Practitioner

Initials

Authorized Title: For example, Registered Credentialed School Nurse

Signature

Date