Los Angeles County Office of Education
School District Health Services Report
2016-2017 School Year

Due by June 30, 2017

School District ______________________________ Completed by _____________________

DISTRICT DEMOGRAPHIC DATA

1. Total # of schools:
   Elem _____ Middle/JHS _____ HS _____ Continuation HS _____ Total ________

2. Total # of students: (Use October CBED Data)
   Total ______

3. Total # of Credentialed School Nurses: Full-Time Equivalent (FTE) _____

4. Coordinating/Lead Nurse:
   Has a school assignment _____ Administrative position only _____

5. Total # of non-credentialed nurses in the district:
   RN FTEs _____ LVN FTEs _____

6. Total # of Health Office Aides: Full-Time _____ Part-Time _____

7. District School-based Health Clinic? Yes____ No ____ # of clinics ____

8. District Immunization Program? Yes____ No ____
STUDENT HEALTH DATA

1. Health Conditions / Diagnoses: (indicate the # of students with each)

<table>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>Asthma</th>
<th>Allergies (Life threatening only)</th>
<th>Autism Spectrum (w/ Restrictions only)</th>
<th>Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding Disorder</td>
<td>Legally Blind</td>
<td>Cancer</td>
<td>Cardiac Impairments</td>
<td>Cerebral Palsy</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Deaf/ Hard of Hearing</td>
<td>Depression</td>
<td>Diabetes Type 1</td>
<td>Diabetes Type 2</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Immune Disorders</td>
<td>Migraines</td>
<td>Muscular Dystrophy</td>
<td>Other Neuromuscular</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>Seizure Disorders</td>
<td>Self-Mutilation</td>
<td>Spina Bifida</td>
<td>Tourettes</td>
</tr>
<tr>
<td>Transplants</td>
<td>Other Mental Health</td>
<td>Other (specify)</td>
<td>Other (specify)</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

2. # of Students with Specialized Physical Health Care Procedures (SPHCS) requiring Assistance/Monitoring:

   a. GI:       GT Tube _____ GT Feeding/Med _____ Colostomy _____

   b. Respiratory: Ventilator _____ Tracheostomy _____ Suctioning _____ Nebulizer _____
      Oxygen – Continuous _____ Oxygen – Standby _____

   c. Neuro:     Vagal Nerve Stimulator _____ Shunt _____

   d. Cardiac:   Central Line _____ PICC Line _____ Pacemaker _____

   e. Urology:   Toileting _____ Catheterization _____

   f. Endocrine: Blood Glucose Testing _____ Ketone Testing _____ Insulin Pump _____
      Insulin: Nurse administered _____ Nurse Assisted _____ UAP _____ Independent _____

   g. Other SPHCS: (specify)_______________________________________________________

3. # of Emergency Medications SPHCS:

   Diastat _____ EpiPens _____ Glucagon _____ SoluCortef _____ Other (specify) _________
## DIRECT SCHOOL NURSING SERVICES

1. **# of Students screened:**

<table>
<thead>
<tr>
<th></th>
<th>Hearing</th>
<th>Vision</th>
<th>Color Vision</th>
<th>Scoliosis</th>
<th>Dental</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Referred</td>
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<tr>
<td>Received Care</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Mandated Screening completed by:**

- [ ] School Nurse
- [ ] Contracted Agency *(agency)*
- [ ] Combination of School Nurse and Agency *(agency)*
- [ ] Other *(explain)*

## HEALTH OFFICE SERVICES

1. **Total # Health Office Visits:**

2. **Medication Administration:**
   - # of students with medication orders
   - # of medication doses given annually

Submit completed form to the CHSS Unit via e-mail or fax.

E-mail: chss@lacoe.edu

Fax: (562) 922-6299