Los Angeles County Office of Education

SCHOOL HEALTH SERVICES
YEAR END REPORT
2017-2018 School Year
Due by June 30, 2018

School District ______________________________  Completed by _____________________

DISTRICT DEMOGRAPHIC DATA

1. Total # of schools: ____________

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

3. Total # of Credentialed School Nurses: FTE ________ (Do not include administrative position)

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

5. Total # of non-credentialed nurses working as 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 _____  Total # Clinics __________

8. District Immunization Program?  Yes_____  No _____

STUDENT HEALTH DATA

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

<table>
<thead>
<tr>
<th>Asthma</th>
<th>Diabetes Type 1</th>
<th>Diabetes Type 2</th>
<th>Seizure Disorder</th>
<th>Life Threatening Allergy</th>
</tr>
</thead>
</table>
2. Types of Specialized Physical Health Care Services (SPHCS) being provided at school: *(List)*

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

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>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received Care</td>
<td></td>
<td></td>
<td>N/A</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. Total # of medication doses given: ____________

*Please complete and submit by email, fax, or mail by June 30, 2018 to:

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Phone: 562-922-6377*