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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Types of Specialized Physical Health Care Services (SPHCS) being provided at school: *(indicate the # of students)*

<table>
<thead>
<tr>
<th>G-tube</th>
<th>Ventilator</th>
<th>Tracheostomy</th>
<th>Suctioning</th>
<th>Nebulizer</th>
<th>Oxygen</th>
<th>Catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PICC &amp; Central Line</th>
<th>VNS</th>
<th>Toiletting</th>
<th>Other</th>
<th>Other</th>
<th>Other</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DIRECT SCHOOL NURSING SERVICES

1. # of Students screened:

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Received Care</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 to chss@lacoe.edu by June 30, 2021*
1. Complete entire survey
   a. Make sure everything is filled out
   b. Do not leave any blanks
   c. If there is none or zero, input 0

2. # of health office visits
   a. Specify the total number of students that visited the health office
   b. This includes the number of students that office clerks or health aides assist in the health office, not just the students seen by the nurse