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>
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<td></td>
</tr>
</tbody>
</table>

Page 1 of 3
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>
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</tbody>
</table>

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

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>N/A</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 28, 2019 to:

Susan Chaides, Project Director III
Los Angeles County Office of Education
Student Support Services, ECW 384
9300 Imperial Hwy, Downey, CA 90242
Email: chss@lacoe.edu
Phone: 562-922-6377
**Instructions**

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