

Student Name:				Date:	Time In:		Time Out:	
Temp:	HR:	RR:	BP:	Disposition: <input type="checkbox"/> RTC	<input type="checkbox"/> Home	<input type="checkbox"/> Doctor	<input type="checkbox"/> ER	
O ₂ Sat:	Blood Sugar:	Peak Flow:	Parent Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Message <input type="checkbox"/> Note Sent Home					
Reason for Visit								
<input type="checkbox"/> Abd Pain <input type="checkbox"/> N - V - D <input type="checkbox"/> Other GI Issue: _____	<input type="checkbox"/> Headache <input type="checkbox"/> Dizzy <input type="checkbox"/> Other Neuro Issue: _____	<input type="checkbox"/> Sore Throat <input type="checkbox"/> Earache <input type="checkbox"/> Other ENT Issue: _____	<input type="checkbox"/> Eye Injury <input type="checkbox"/> Eye Foreign Body <input type="checkbox"/> Other Eye Issue: _____	<input type="checkbox"/> Wound <input type="checkbox"/> Rash <input type="checkbox"/> Other Skin Issue: _____				
<input type="checkbox"/> Malaise <input type="checkbox"/> Toothache <input type="checkbox"/> Emotional: _____	<input type="checkbox"/> Asthma Exacerbation <input type="checkbox"/> Cough <input type="checkbox"/> Other Resp Issue: _____	<input type="checkbox"/> Injury (head) <input type="checkbox"/> Injury (m/s) _____ <input type="checkbox"/> Other Injury: _____	<input type="checkbox"/> G/U _____ <input type="checkbox"/> C/V _____ <input type="checkbox"/> Endocrine _____	<input type="checkbox"/> Other _____ _____ _____				
Assessment Findings								
Abd Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		C/V Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		ENT Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		Neuro Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		
Ortho Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		Resp Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		Skin Assessment <input type="checkbox"/> WNL <input type="checkbox"/> Other: _____ _____		Other: _____ _____		
Action Taken								
<input type="checkbox"/> Rest in Nurse's Office <input type="checkbox"/> Cleansed & dressed wound <input type="checkbox"/> RICE <input type="checkbox"/> PRN Medication _____				<input type="checkbox"/> Snack <input type="checkbox"/> PO Fluids <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____				
Additional Information:								

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