PHYSICAL ASSESSMENT

CHECKLIST for

SUSPECTED SUBSTANCE

ABUSE

School: _____

NAME:	**GR/RM #:**		**Time In:**	**Time Out:**
	DOB:	**M / F**	**VITALS**	
Dear Parent/Guardian: Your child reported to the Health Counselor's Office today for the following reason(s).			**BP:**	**T:**
			O2 Sat:	**P:**
			Pain Scale:	**R:**

Medical History:	**Referred by:**	**Allergies:**	**Other:**
Behavior/ Appearance & Level of Consciousness	( ) Alert & oriented ( ) Angry ( ) Agitated/ Argumentive ( ) Anxious ( ) Belligerent ( ) Bored ( ) Combative /violent	( ) Drowsy ( ) Confused ( ) Cooperative ( ) Dazed ( ) Disoriented ( ) Irritable ( ) Hallucinations	( ) Lethargic ( ) Stuporous ( ) Obtunded ( ) Jittery ( ) Paranoid ( ) Poor Coordination ( ) Restless ( ) Scared ( ) Sense of Euphoria Feeling high ( ) Other
Odor:	( ) Tobacco	( ) ETOH	( ) Other
Gait:	( ) Steady	( ) Weaving/needs help to walk	( ) Holding or reaching
Eyes: & Pupils:	( ) Wide eye ( ) Pinpoint	( ) Droopy eye ( ) Dilated ( ) Blank stare	( ) Red ( ) Watery ( ) Glassy
Speech:	( ) Normal	( ) Rapid/ raspy ( ) Incoherent ( ) Mumbling	( ) Slow ( ) Slurred ( ) Loud noisy
Other Signs and Symptoms	( ) Excessive perspiration	( ) Flushed face	( ) Frequent trips to restroom
( ) Chills and sweating	( ) Dizziness	( ) Dry mouth	( ) Tremors ( ) Twitching
( ) Muscle cramping	( ) Teeth clenching	( ) Nausea	( ) Vomiting
( ) Nystagmus	( ) Seizures	( ) Dizziness	( ) Other

How do you feel?

_____

Do you know why you have been referred to the School Nurse office?

_____

History:

Are you currently ill? **Y / N** Explain:

_____

Have you ever had a seizure? **Y / N** Explain:

_____

Have you ever had a head injury? **Y /N** Explain:

_____

Are you on any medications? **Y / N** Name of medication(s): _____

Have you taken any drugs or alcohol? **Y / N** Specify? _____

What time did you wake up today? _____ How many hours of sleep did you get last night? _____

Comments:

_____

_____

_____

_____

_____

	Instructions/Recommendations/Disposition
	Recommend rest and fluids.
	I recommend that you observe your child carefully and take him/her to the doctor if deemed necessary.
	I recommend that you take your child and this form to the doctor or clinic as soon as possible.
	Your child may return to school when fever free for 24 hours without fever reducing medications.
	Must provide a written clearance from a doctor or medical provider before returning to school.
	Head injury precautions: Be alert for symptoms that worsen over time. Take your child to the ER right away if you observe any loss of consciousness, convulsions, headaches, dizziness, nausea, vomiting, slurred speech, drowsiness, and/or changes in personality.
	Please keep injury clean and dry and observe for signs of infection (redness, swelling, yellow discharge, increased pain and temperature)
	Student was referred to School Administrator Time:
	911 called Time:_____ Time EMS arrived at school: _____ School Personnel Accompany EMS:
	Refused EMS Transport: _____ _____ Print Name Signature Relationship

School Officials Signatures
School Administrator/Designee Name: **Signature:**
School Health Counselor (SHC) or: **Licensed Practical Nurse (LPN) name and signature:**