



HEALTH REQUIREMENTS AND SERVICES:  
MEDICAL TREATMENT

<p>Student Outcome:</p> <p><input type="checkbox"/> No change was observed in student's condition</p> <p><input type="checkbox"/> Did not cause complications or Required medical intervention</p> <p><input type="checkbox"/> Other:</p> <p><input type="checkbox"/> No medical intervention required</p> <p><input type="checkbox"/> Student required medical attention (Include details): _____</p> <p><input type="checkbox"/> Produced a temporary or Localized response</p>
<p>Parent notification:</p> <p>Date: _____ Time: _____ am/pm By Whom: _____</p> <p>Additional notes:</p>
<p>School Registered Nurse notification:</p> <p>Date: _____ Time: _____ am/pm By Whom: _____</p> <p>Additional notes:</p>
<p>Principal notification:</p> <p>Date: _____ Time: _____ am/pm By Whom: _____</p> <p>Additional notes:</p>
<p>Director of Nursing &amp; Health Services notification:</p> <p>Date: _____ Time: _____ am/pm By Whom: _____</p> <p>Additional notes:</p>
<p>Licensed prescriber notification:</p> <p>Date: _____ Time: _____ am/pm By Whom: _____</p> <p>Additional notes:</p>

Signature of person completing report: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_

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