ECISD Nursing & Health Services

ECISD IMPAIRMENT ASSESSMENT

STUDENT INFORMATION					
Name of Student:		Date of Birth:		Student ID:	
School:		Grade:		Referred By:	

ASSESSMENT					
Accompanied By:		Date:		Start Time:	

REASON FOR ASSESSMENT

Current Medication(s) – OTC & Prescribed	Last Dose Taken

PHYSICAL FINDINGS					
Vital Signs:	Blood Pressure:	Pulse:	Respirations:	O2 Sats:	Temp:

LEVEL OF CONSCIOUSNESS			
Oriented to time, place, person:	☐ Yes ☐ No	Short term memory intact:	☐ Yes ☐ No

BEHAVIOR FINDINGS

Activity Level (*check all that apply*)

☐ Confused ☐ Hyperactive ☐ Irritable ☐ Restless ☐ Slow ☐ Uncooperative ☐ Normal

SPEECH (*check all that apply*)

☐ Incoherent ☐ Rambling ☐ Slurred ☐ Normal

ANY PHYSICAL COMPLAINTS REPORTED BY STUDENT?

Check: ☐ Yes ☐ No	If YES, please describe:
Last time student had something to eat:	

EYE INDICATORS

Eyes (*check all that apply*)		RIGHT	LEFT			RIGHT	LEFT
Reaction to Light:	Reactive			Sclera:	Normal		
	Slow				Bloodshot		
	No Reaction				Watery		
Pupil Size:	Normal			Nystagmus:		☐ Positive ☐Negative	☐ Positive ☐Negative
	Constricted						
	Dilated						

ADDITIONAL PHYSICAL SIGNS (*check all that apply*)

☐ Runny Nose ☐ Bloody Nose ☐ Pale ☐ Tremors ☐ Flushed ☐ Vomiting ☐ Sweating ☐ Other (*explain*)

Explain (Other):	

DID STUDENT REPORT ANY SUBSTANCE USE?

☐ Yes ☐ No	If YES, list name of substance(s), when used, amount used, route used:	

ANY ODOR DETECED ON STUDENT?

Breath	☐ Yes ☐ No	Hands	☐ Yes ☐ No	Hair	☐ Yes ☐ No	Clothing	☐ Yes ☐ No

☐ Administrator Notified/Received Completed Assessment	☐ Campus Officer Notified/Received Completed Assessment
Nurse Signature:	Time Completed: