	LOS ANGELES UNIFIED SCHOOL DISTRICT
Location Code	SCHOOL NURSE HEALTH OFFICE DAILY LOG

District____ School _

PRINT SCHOOL NURSE Name						Signature								Employee #															
						Heal	lth E	d for	for s disea	ase p	reve	ntior	n		&	sess Educ	ation	s	sych ocial	(Use diagnosis or diagnosis		Di	spo	sitio	on		Sp	ecia	ıl Ed
ية Date		Print Student Name	MM DD YY	Reason for Referral	Temp	Dental Screen	Eye	Gastrointestinal	Hair	Hygiene	Ortho/Scoliosis	Skin	LE TE	Other:put in comments	Audiometric Exam	Developmental Exam	Vision screen	Color Vision	RARD SS 8572	\$\(\begin{array}{c} \frac{1}{2} \\ \text{Min} \\ Min	Return to class	Readmit	1st Aid Note Head Injury Note	Vision/CV Note	Medication All other exclusions	CD EXCL W/LETTER	Initial IEP	3 year IEP	Implement IEP 504 Other Nirs Care Plan
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		ORIGINAL Copy: Health Office confid	dential files Y	ELLOW copy: due the 5th day each	n month			_	Hair H ing Se			Skin l	URIU	П	Aud	DE N	t VS	cv		Medi-Cal Form 308 Rev (6/03)				Н				ш	