

# Nursing Services Record – Procedures

Student Name: _____	DOB: _____	ID: _____
Month of Service/Year: _____	Service Duration (IEP Dates): _____	Group: 1
School: _____	Grade: _____	

Procedure Codes	Explanation and/or Instructions
1= Blood Glucose	
2 = Blood Pressure	
3 =Catheterization	
4 = Tube Feeding	
5 = Other	

Date	Code	Start Time	Total Time	Initials	Code	Start Time	Total Time	Initials	Code	Start Time	Total Time	Initials
1												
2												
3												
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**Monthly Procedure Summary (LSN Review)**

Student Tolerated Procedure(s): Yes <input type="checkbox"/> No <input type="checkbox"/>	Changed in Procedure(s): Yes <input type="checkbox"/> No <input type="checkbox"/>
Concerns Noted (if yes, comment): Yes <input type="checkbox"/> No <input type="checkbox"/>	Continue Plan: Yes <input type="checkbox"/> No <input type="checkbox"/>

**Comments**

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**Health Associate/Paraprofessional:**

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Licensed School Nurse:**

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**The original should be placed in the building file for all students.  
For Third Party Billing students, send a copy to Donniel Robinson at the DAO monthly.**