



Name: _____ DOB: _____ Student ID # _____
Campus: _____ Grade: _____ Date: _____

Home address: _____
Home phone: _____

Parent/guardian: _____
Home phone: _____ Work Phone: _____
Cell phone: _____ Pager: _____

Parent/guardian: _____
Home phone: _____ Work Phone: _____
Cell phone: _____ Pager: _____

Student lives with: _____
Special circumstances: _____

In case of an emergency or if student is ill and parents cannot be reached, who should be contacted?

Name: _____ Relationship: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____

Name: _____ Relationship: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____

Physician: _____
Address: _____
Office phone: _____ Fax: _____

Physician: _____
Address: _____
Office phone: _____ Fax: _____

Physician: _____
Address: _____
Office phone: _____ Fax: _____

Preferred Hospital: _____
Phone: _____



Name: _____ DOB: _____ Student ID # _____
Campus: _____ Grade: _____ Date: _____

Medical History/Assessment:

Diagnoses: _____

Injuries/illnesses/hospitalizations/surgeries: _____

Medications:	Strength	Dose	Time Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Baseline Vital Signs: T _____ HR _____ RR _____ BP _____ Peak flow: _____

Neurological: _____

Respiratory: _____

Cardiac: _____

Nutrition: _____

G/I: _____

G/U: _____

Mobility: _____

Skin: _____

Psychosocial: _____

Communication: _____

Notes: _____



Name: _____

DOB: _____

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Nursing Diagnoses:

Goals:

Interventions:

Evaluation:
