Pomona Unified School District
School Nurse Data Sheet

☐ **SST**

☐ **504**

Name _____

School _____ Grade _____ Date of Birth _____

Physician _____ Phone _____

Has the parent signed a consent for release of medical information? ☐ Yes ☐ No

Does the student have an existing Specialized Health Care Plan? ☐ Yes ☐ No

Who monitors the plan? _____

Is medication to be given at school? ☐ Yes ☐ No At what times? _____

Who monitors the administration of medication? _____

Where is the medication kept? _____

Does the student have a condition that warrants him/her to carry the medication on their person? (i.e. asthma inhaler) ☐ Yes ☐ No

Have the teacher(s), aide(s) been in serviced on the nature of the medical condition? ☐ Yes ☐ No

Additional Information:

Review date: