LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REVIEW FOR SUPPORT SERVICES DUE TO HEALTH NEEDS

SCHOOL NURSE COMPLETES THIS FORM IN COLLABORATION WITH THE SITE ADMINISTRATOR PRIOR TO THE IEP MEETING

☐ **Initial** ☐ **Continuing**

Student Name:	Student ID#

School:	Phone:	Fax:
Grade:	☐ General Ed Class ☐ Special Day Class	

School Nurse:	IEP Date:

Health needs requiring support:

Does the student's condition require continuous monitoring and supervision? ☐Yes ☐No
If yes, describe specific health needs:

Check the specialized physical health care procedures that the student requires:

☐ **Gastrostomy Feedings** ☐ **Oxygen Therapy**

☐ **Catheterization** ☐ **Tracheostomy Care and Suctioning**

☐ **Oral Suctioning** ☐ **Dysreflexia Procedure**

☐ **Other:** _____ ☐ **Gastrostomy Tube Replacement**

The student requires services from a Licensed Nursing Provider for the following reason:

School Nurse: Please fax this form to District Nursing Services at (213) 765-3868. If a need becomes known during the IEP meeting, call District Nursing Services for consultation at (213) 765-2800.

District Nursing Services (DNS) Review: _____

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DNS Signature: _____ **Date:** _____