

Nurse Case Management: Intake / Annual Assessment Form

Student Name _____ Grade _____ Date of Birth _____

Known Diagnoses _____

Current Medications _____

Medical Home _____ Date of Last HCP Visit _____

Number of ER Visits this year _____ Date of Most Recent ER Visit _____

Date of Most Recent Hospitalization _____

Knowledge of Health Condition Non Littl Som Thoroug

Skill in Self-managing Health Condition Non Littl Som Thoroug

Height _____ Weight _____ BMI _____ Temp _____ Pulse _____ Respiration _____ Blood Pressure _____

Head Neck _____ Eyes _____ Ears _____ Teeth _____ Heart Sounds _____

General Appearance _____

Skin Hair Nail _____

Breath Sounds _____ Respiratory Effort _____ Abdomen _____

Nutrition _____ Arms Legs _____ Hand Strength _____

Notes

Current Plans

- | | |
|------------------------------|-----------------------------------|
| <input type="checkbox"/> IE | <input type="checkbox"/> IHP/EC |
| <input type="checkbox"/> 504 | <input type="checkbox"/> Behavior |

Living Arrangement

Behavior Health Risks

(check all that apply)

<input type="checkbox"/> Mental Health
<input type="checkbox"/> Substance Abuse (ATOD)
<input type="checkbox"/> Sexual Activity
<input type="checkbox"/> Disordered
<input type="checkbox"/> Cutting or Self-
<input type="checkbox"/> Suicidal
<input type="checkbox"/> Other (below)

Impaired School/Social Function

(check all that apply)

<input type="checkbox"/> Behavior Issues / Discipline referrals
<input type="checkbox"/> Suspended /
<input type="checkbox"/> Family
<input type="checkbox"/> History of Academic
<input type="checkbox"/> Truancy
<input type="checkbox"/> Stress
<input type="checkbox"/> Anger
<input type="checkbox"/> Bullied /
<input type="checkbox"/> High Antisocial / Negative Peer
<input type="checkbox"/> Other (below)

Family History

<input type="checkbox"/> Mental Health Condition
<input type="checkbox"/> Substance Abuse (ATOD)
<input type="checkbox"/> Incarceration
<input type="checkbox"/> Other (below)

Strengths: (check all that apply or list specifics)

Belonging

Student	Nurse
<input type="checkbox"/> Family	<input type="checkbox"/>
<input type="checkbox"/> Peer	<input type="checkbox"/>
<input type="checkbox"/> Community	<input type="checkbox"/>
<input type="checkbox"/> Pro-Social	<input type="checkbox"/>
<input type="checkbox"/> ID 1 Caring	<input type="checkbox"/>

Independence

Student	Nurse
<input type="checkbox"/> Control of Actions	<input type="checkbox"/>
<input type="checkbox"/> Control of	<input type="checkbox"/>
<input type="checkbox"/> Control of	<input type="checkbox"/>
<input type="checkbox"/> Control of	<input type="checkbox"/>
<input type="checkbox"/> Other (below)	<input type="checkbox"/>

Subject	<input type="text"/>	<input type="text"/>
Hobby	<input type="text"/>	<input type="text"/>
Talent	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>

Identify Concerns

<input type="text"/>

Priorities

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Plan

<input type="text"/>
