LOS ANGELES UNIFIED SCHOOL DISTRICT
SPECIALIZED PHYSICAL HEALTH CARE SERVICES
2025/2026

ALL STUDENT DIAGNOSIS MUST BE ENTERED INTO WELLIGENT

School:	Region:	Phone:	Ext:	School Nurse:

STUDENTS WITH DIABETES

Name	Birth Date	Grade	Blood Glucose Testing Schedule	CGM	Carb Coverage	Insulin Correction	Pump	Pen	Syringe	Glucagon	Procedure Performed By
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		
							☐	☐	☐		

School Personnel Training Date: _____

_____ Number of students with diagnosed Asthma
_____ Number of students who self-carry Asthma
_____ Number of students with Asthma Action Plans from Health Care Provider
_____ Number of students on Quick Relief/Rescue Inhalers at school

STUDENTS WITH ASTHMA Needing Mechanical Nebulizer (not inhalers)

Name	Birth Date	Grade	Medication:	Mechanical Nebulizer Treatment At School		
				Time	PRN	Procedure
					☐	
					☐	

School Personnel Training Date: _____

STUDENTS WITH SEVERE ALLERGY Needing the Epinephrine Auto Injector

Name	Birth Date	Grade	Auto Injector: Severe Allergy To

School Personnel Training Date: _____

This form is due by **Friday September 19, 2025** to your Region Nursing Office.
Notify your Region Nursing Office immediately of additions or changes as they occur during the school year.
Place a copy of this form in the School Nurse Substitute Folder.

LOS ANGELES UNIFIED SCHOOL DISTRICT
SPECIALIZED PHYSICAL HEALTH CARE SERVICES (Special Procedures)
2025/2026

ALL STUDENT DIAGNOSIS MUST BE ENTERED INTO WELLIGENT

DO NOT include Asthma/Allergy or Diabetic procedures listed on front of form

School:	Region:	Phone:	Ext:	School Nurse:

Are there other Licensed Health Care Providers (LVN/RN) are on your campus? (includes Non-LAUSD staff, i.e. Non-Public Agency, Contractor etc.)	No ☐	Yes ☐	Number of Health Care Assistants

					Procedure Performed By:					
Name	Birth Date	Grade	Special Procedure	Time	RN	LVN	HCA	Student	Student w/ Supervision	Other
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	
					☐	☐	☐	☐	☐	

_______ Number of students diagnosed with Seizure Disorder

STUDENTS WITH SEVERE SEIZURES with a Diastat, VNS, and Nasal Benzodiazepine order

Name	Birth Date	Grade	Name	Birth Date	Grade	Name	Birth Date	Grade

School Personnel Training Date: ___________

Notify your Nursing Coordinator immediately of additions or changes as they occur during the school year by updating and submitting this form.