Generic Nursing Assessment Form 2020-2021 DATE: _____

DIAGNOSIS: _____

Student Name: _____ Date of Birth:_____ Grade: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Primary Healthcare Provider: _____ IHS CMC LRCHC OTHER (circle one)

Phone: _____

Specialty Healthcare Provider: _____

Phone: _____

Has your child received a diagnosis from a healthcare provider? _____ YES _____ NO

History and Current Status:

- Date of Diagnosis: _____
- Symptoms: _____
- How often: _____
- Routine Care: _____

Triggers and/or Symptoms

- What are early signs? _____
- How does your child communicate or show his/her symptoms?
  _____

Treatment

- Past: _____
- Emergency Room Visit: _____ YES _____ NO. If yes, date: _____
- Admitted to Hospital? If yes, where and when? _____

- Has your healthcare provider provided you with a prescription for medication? If yes, name of medication: _____
- Is the medication used routinely? _____ weekly _____ daily _____ more than once/day
- Or is this medication used when needed ("prn")?
- Please describe other treatments:
  _____
  _____
  _____

Self-Care

- Is your child aware of symptoms? _____
- Does your child let others know about symptoms? _____

Family/Home

- How is your child's diagnosis dealt with at home? _____
- Do you feel the family is coping well with the diagnosis? _____

General Health

- How is your child's health? _____
- Does your child have other health conditions? _____
- Hospitalizations? _____
- Concerns: _____

Notes:

Parent/Guardian Signature: _____ Date: _____

RN Signature: _____ Date: _____