

CCSD Individual Student Documentation Log

Student Name:		Grade:	Date:	Time in:	Time out:
Nature of Visit: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Occurrence		Employee Name & Signature:		Vital Signs - <input type="checkbox"/> Temp: <input type="checkbox"/> Other:	
Narrative:					
<input type="checkbox"/>	Allergy/Hives	<input type="checkbox"/>	Eye Injury/Issue	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Fall		
<input type="checkbox"/>	Bites	<input type="checkbox"/>	Fever		
<input type="checkbox"/>	Bloody Nose	<input type="checkbox"/>	Headache		
<input type="checkbox"/>	Body Aches	<input type="checkbox"/>	Illness		
<input type="checkbox"/>	Bruise	<input type="checkbox"/>	Incontinence		
<input type="checkbox"/>	Burn	<input type="checkbox"/>	Insect/Spider Bite or Sting		
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Mental Health Issue		
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Nausea/Vomiting		
<input type="checkbox"/>	Cold	<input type="checkbox"/>	Not Feeling Well		
<input type="checkbox"/>	Congestion/Cough	<input type="checkbox"/>	Pain		
<input type="checkbox"/>	Cut/Scrape/Wound	<input type="checkbox"/>	Possible Dislocation/Fracture/Sprain		
<input type="checkbox"/>	Dental Issue	<input type="checkbox"/>	Stomachache		
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Difficulty Breathing/Shortness of Breath				
<input type="checkbox"/>	Earache				
Treatment					
<input type="checkbox"/>	Ace Wrap/Coban	<input type="checkbox"/>	Emergency Care		
<input type="checkbox"/>	Active Listening	<input type="checkbox"/>	Hydration		
<input type="checkbox"/>	Band-Aid/Bandage	<input type="checkbox"/>	Cold Compress/Ice Applied		
<input type="checkbox"/>	Calming Techniques	<input type="checkbox"/>	Rest		
<input type="checkbox"/>	Changed Clothes	<input type="checkbox"/>	Sling/Splint Applied		
<input type="checkbox"/>	Cleaned/Dressing Applied	<input type="checkbox"/>	Snack Eaten		
<input type="checkbox"/>	Compression	<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Elevation				
Disposition & Notification					
<input type="checkbox"/>	911/EMS	<input type="checkbox"/>	Parent/ER Contact Notified		
<input type="checkbox"/>	Returned to Class	<input type="checkbox"/>	Time Parent/ER Contact Was Notified:		
<input type="checkbox"/>	Going Home Per Parent Decision	<input type="checkbox"/>	Unable to Contact Parent/ER Contact		
<input type="checkbox"/>	Sent Home w/Parent/ER Contact	<input type="checkbox"/>	Number of Attempts to Contact Parent/ER Contact		
<input type="checkbox"/>	Stayed in Office	<input type="checkbox"/>	Other:		

*Head injury, diabetes, medication administration and seizures are documented on their own individual CCSD forms/online.