Medical Clinical Service Note

Student's Name:	**Student #**	**Date of Birth:**
School:	**Teacher:**	**Grade Level:**
Medication:	**Dosage:**	**Doctor's Orders or PRN:**
Dr. Name	**ICD Diagnosis:**	**Date/Time Form Completed:**

DATE: _____ TIME IN: _____ TIME OUT: _____

Health Care Provider Location: _____

Nurse's Observation of the Medical Encounter and Treatment Provided:

_____

_____

_____

Student's Response to Treatment: _____

_____

Comments: _____

_____

Nurse Name Print: _____ Nurse Signature: _____ Date: _____