Employee Health Suite Visit Form

For all visits except health counseling

Return form to Office, Employee Absence and Risk Management * Fax 410-337-0160 * Email: ORM@bcps.org

TO BE COMPLETED BY EMPLOYEE

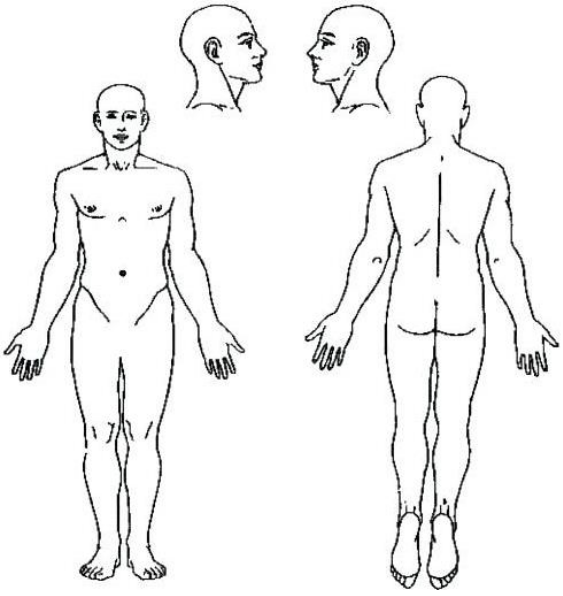
Name of Employee: _____ **School/Office:** _____

Position: _____ **DOB**: _____

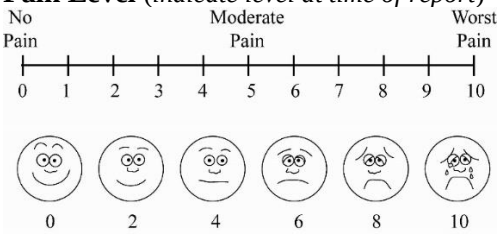
Today's Date: _____ **Time**: _____ **Date of Onset**: _____

Reason For Visit:

Body Part(s) Involved *(indicate on diagram)*



Pain Level (*indicate level at time of report*)



Description of Injury/Illness
(if injury, include how it occurred)

(Name of Person Completing Form) (Signature of Person Completing Form) (Date)

TO BE COMPLETED BY SCHOOL NURSE

Assessment:

Interventions:

☐No Treatment Rendered ☐First Aid *(describe)*:

☐Ambulance ☐Refer to Health Care Provider ☐Other *(describe)*:

Any additional notes:

(Name of Nurse) (Signature of Nurse) (Date)

Note: Work injuries and illnesses need to be reported per Board Policy and Rule 4204. An employee may seek medical treatment for work-related injuries with a Board-approved medical provider (Concentra) or with a private/personal provider.