NURSING SUPPORT SERVICES
CHILD HEALTH ASSESSMENT
DELEGATED CARE

Child's Name: Last Name, First Name DOB: YYYY-MM-DD

☐ New Delegation ☐ Annual Re-assessment	NSS COORDINATOR	DATE OF REFERRAL (YYYY/MM/DD)	ASSESSMENT DATE (YYYY/MM/DD)

PERSONAL INFORMATION

LAST NAME OF CHILD	FIRST NAME OF CHILD	MIDDLE NAME OF CHILD	DATE OF BIRTH	CHILD'S PHN	GENDER ☐M ☐F

NAME OF PARENT(S)/GUARDIAN(S)	RELATIONSHIP TO CHILD	DAYTIME PHONE NUMBER	EVENING PHONE NUMBER

FULL ADDRESS	CITY	PROVINCE	POSTAL CODE	EMAIL ADDRESS

Primary Diagnosis:	•
Secondary Diagnosis:	•
Delegated Care Needs:	•

Reassessment Date:		**Date of Consent:**	

Current Consulting Health Professionals/Other Services/Supports (Specific Names Not Required):	**Child's Health History** (Brief Bulleted Summary Relevant to Delegated Care Plan): •

CURRENT HEALTH HISTORY (Summary):

Allergies:	•
Goals Of Care **(Child & Family)**	•
Equipment:	•

Medications	Dosage	Route

Child's Name: Last Name, First Name DOB: YYYY-MM-DD

SYSTEMS SUMMARY: Please include as applicable to current delegated care plan:
Symptoms: presentation, frequency, interventions and typical response/outcomes
Adverse Events History – presentation, frequency, interventions, outcome

	X if **Not** Applica	**If applicable**, provide brief overview of factors relevant to delegated care plan – *maximum 4 bullet points*
Respiratory:	☐	•
Cardiovascular:	☐	•
Gastro-Intestinal/ Nutrition:	☐	•
Genito-Urinary/ Elimination:	☐	•
Musculoskeletal/ Mobility:	☐	•
Neurological/ Seizures:	☐	•
Endocrine:	☐	•
Integumentary/Skin/ Integrity:	☐	•
Comfort/Pain:	☐	•
Sleep/Rest: describe night time care	☐	•
Communication: hearing, vision, speech	☐	•

Activities of Daily Living (Please provide brief bulleted overview – List the interventions & frequency required to provide delegated care for child)	•
Psycho-Social/Family/ Spiritual/Cultural Factors (Please provide brief bulleted overview as applicable to delegated care plan; integrate family strengths and support	•

capacity-building)	
Information Obtained From	•

ASSESSED AND SUBMITTED BY:		
NSS COORDINATOR NAME	NSS COORDINATOR SIGNATURE	DATE SIGNED (YYYY/MM/DD)