Division of Public Health
Payment Voucher for Non-Public School Nursing Service

Due by the 5th of each month
Email Amanda McLain at:
amclain@cdow.org
PH: 302-573-3133
FAX: 302-573-6945

Month: _____Year:_____
Voucher month/year

	Hours Worked		
Date	From	To	Total
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

*Total hours do not include lunch.

Signature of Nurse and Professional Licensure:

_____

Nurse:_____
Print name

Lic.#: _____

Exp. Date: _____

School: _____

Enrollment: _____

Emergency card on file for all students: _____
(100% Compliance)

REPORT ON NURSING ACTIVITY DURING PAYMENT PERIOD:

1. Tuberculin Tests (read only):
   Positive ___Negative _____Other _____
2. Conferences (Total Time Spent): _____
3. Teaching Time: _____
4. Screening Evaluations:

Type of Screening (Write in) 90% Compliance	Total # Served	Number Referred for Medical Attention	**Number who Received Medical Attention
Vision			
Hearing			
Posture/Gait			
Blood Pressure			
Ht/Wt			
Immunization/ Health Record Review			

** Enter number of referred children who have received medical attention for those items since last payment period.

5. Acute Care (illness, injury, and other problems)
   a. Type of Screening: Illness _____ Injury_____
      Miscellaneous_____ Prescription Meds _____
   b. Total Number Served _____
   c. Number Referred for Medical Attention and documented in file _____ (90% Compliance)
   d. Number Who Received Medical Attention _____
   e. Total Number of Medications Given (Rx and non-RX) _____
   f. Number of Unduplicated Students _____

Authorization Signature: _____

Title:_____Date:_____