

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>3+</u> L <u>3+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" type="checkbox"/> Friendly <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL		
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	ELIMINATION Urine Appearance: <u>Clear, yellow</u> Stool Appearance: _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: <u>left anterior antecubital</u> <input checked="" type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>peripheral IV line</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>NA</u> <u>Fluid restriction - 800ml</u>
GASTROINTESTINAL		
	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input checked="" type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____ <u>Rounded distention from fluid</u>	SKIN Color: <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ Mucous Membranes: Color: _____ <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
RESPIRATORY		
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ <input type="checkbox"/> Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____	NUTRITIONAL Diet/Formula: <u>reg. Diet</u> Amount/Schedule: <u>100%, 100% eaten</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	PAIN Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: <input type="checkbox"/> 0800 _____ <input type="checkbox"/> 1200 _____ <input type="checkbox"/> 1600 _____
MUSCULOSKELETAL		
	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input checked="" type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	WOUND/INCISION <input checked="" type="checkbox"/> None Type: <u>peripheral IV line</u> Location: <u>left anterior antecubital</u> Description: _____ Dressing: <u>clean, dry, intact</u>
MOBILITY		
	<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

**Covenant School of Nursing
Community Service Verification Form
Instructional Module 5**

This is to verify that Hannah McRight has completed community service hours as part of the IM5 course requirement.

Date: 9/3/25

Facility/Organization: Central Elementary

Time In: 8:00

Time Out: 12:00

Supervisor: N. Mowery

Contact Information (phone or e-mail): 800-787-8599

Comments: Super nice!

For questions or comments, please contact Jodi Tidwell (806) 543-4372 or tidwellj1@covhs.org