

PINELLAS COUNTY SCHOOLS
DOCUMENTATION OF NEED FOR HEALTH RELATED SERVICES

☐ ESE ☐ NON-ESE

Student _____ DOB _____

Student Number _____ School _____

Date of IEP or Date of Referral _____

Diagnostic Code/Clinical Impression _____

The following services are needed to help your child benefit from educational experiences provided at school:

☐ Nursing services and/or medication administration* _____ / _____
Signature of Nurse Title Date (on or after IEP date)

☐ Behavioral Services* _____ / _____
Signature of Psychologist or Social Worker Title Date (on or after IEP date)

☐ Therapy Services* _____ / _____
Signature of Speech, Occupational or Physical Therapist Title Date (on or after IEP date)

☐ Attended IEP Virtually (No explanation of need required)

Referral Source:

☐ IEP Team ☐ MTSS ☐ SBLT ☐ CST ☐ PBIS ☐ Teacher ☐ Parent ☐ Self ☐ 504 ☐ Other

* Explanation of need (required): Includes evaluation, reevaluation, counseling, and/or consultation to meet goals on the IEP/FSP.

Behavior Services only, see below:

Note: The need for all health-related services (nursing, behavioral) must be referenced on the student's IEP/FSP or plan of care for purposes of medicaid billing. If service provider is not in attendance at the IEP meeting, this form must be completed prior to billing.