Community Health Nursing Department

Faculty of Nursing

Community Health Nursing Practice Sheet

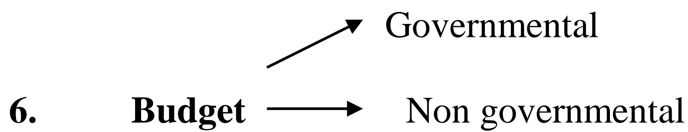
4th year Students

2023-2024

Field trip Report

<u>Field trip</u>

1. **Name:-**
2. **Address:-** **- Tel. No.:-**
3. **Objective:-**
4. **Workers number :-**
5. **Conditions:-**



6. **Budget**
7. **Area served:-**
8. **Population served:-**
9. **Services given:-**
10. **Comments:-**
11. **Future plan:-**
12. **Ways of referral:-**
13. **Role of community health nurse:-**

Presentation evaluation sheet

Student's name:-

Year:- **Group:-**

Presentation topic:-

Presentation elements	**Done**	**Not done**	**Degree**
Written part: 1- Cover sheet. 2- Complete outlines. 3- Setting of goals and objectives. 4- Organized presentation. 5- Introduction 6- Contents covering the outlines. 7- Recent references written correct.			
Oral part: 1- Good communication with staff and students. 2- Explain the objectives. 3- Well explain for each item. 4- Give examples. 5- Voice clear and loud. 6- Good language and self confidence. 7- Encourage participation and cooperation. 8- Time limit.			
Total			

*** Demonstrator signature:-**

School Assessment Sheet

School area evaluation

Student name:
Group:

Item	Student grade	Remarks
1- Attendance		
2- Appearance/ Uniform. Responsibility & assignment.		
3- Behavior& communication.		
4- Nursing care plan: - Assessment. - Ng. diagnosis. - Goals & outcomes. - Implementation & Rational. - Evaluation.		
5- clinical performance		
6- Activities: - Health class - Presentation. - Media.		
7- Exam		
Total		
* student signature.		

*** Demonstrator signature:**

School Assessment Sheet

1- School's name:

2- Address:

3- Health services:

A) Medical examination: - Done ( ) Not done ( )

B) Screening test:-

- Vision Yes ( ) No ( )
- Hearing Yes ( ) No ( )
- Speech Yes ( ) No ( )

C) Preventive Measures of communicable diseases:-

1-Immunization:-

- Booster dose of DT in 1st & 4th year of primary school.

Yes ( ) No ( )

2- Health education: - Yes ( ) No ( )

D) First aid: - Done ( ) Not done ( )

4- Social services: - Yes ( ) No ( )

5- Environment services: - Yes ( ) No ( )

- Building: - Suitable ( ) Non suitable ( )
- Ventilation: - Natural ( ) Artificial ( )
- Lightning: Natural or sunlight ( ) Artificial ( )
- Classroom: Suitable ( ) Not suitable ( )
- Desks and seats: Suitable ( ) Not suitable ( )

- Water supply: Yes ( ) No ( )
- Sewage disposal : Yes ( ) No ( )
- Insect control: Yes ( ) No ( )
- Bath room: Yes ( ) No ( )

Food sanitation:-

- Canteen: Yes ( ) No ( )

Food handler:

- Inside: Yes ( ) No ( )
- Outside: Yes ( ) No ( )

▪ **<u>The student comment:</u>**

- **Real role of the school nurse:**

McH Sheet

MCH area evaluation

Student name:
Group:

Item	Student grade	Remarks
1- Attendance		
2- Appearance/ Uniform. Responsibility & assignment.		
3- Behavior& communication.		
4- Nursing care plan: - Assessment. - Ng. diagnosis. - Goals & outcomes. - Implementation & Rational. - Evaluation.		
5- clinical performance		
6- Activities: - Health class - Presentation. - Media.		
7- Exam		
Total		
* Student signature.		

*** Demonstrator signature:**

Antenatal Care Sheet

-Date ---

-Mother name---------------------------------- -Age--------------

-Occupation---

- Reason for admission --

-Antenatal --------------- weeks/ month

Medical history:

- D. M. ( )

-Hypertension ( )

-Kidney disease ( )

- Heart disease ( )

-Anemia ( )

Others (specify) --

Family history of:

- D.M. ( ) -Hypertension ( )

Obstetrical history:

- No. of living children--------------------------- -

-No. abortions--------------------------

-No. of still births ------------------------------

-No. of low birth weight---------------

-Age of the youngest child---------------------

Previous complications:

- Ante partum hemorrhage Yes ( ) No ( )

-Toxemia: pre-eclampsia Yes ( ) No ( )

- Eclampsia Yes ( ) No ( )
- Poly -hydrominos Yes ( ) No ( )
- Ectopic pregnancy Yes ( ) No ( )

Type of delivery:

- Normal ( ) - Abnormal ( )

If Abnormal delivery:**-**

-Cesarean section ( )

-Ventose ( )

-Forceps ( )

-Precipitative labor ( )

-Prolonged labor ( )

- Post partum hemorrhage Yes ( ) No ( )

-Neonatal jaundice Yes ( ) No ( )

-Neonatal death (within one week) Yes ( ) No ( )

-Others (specify) ------------

Present pregnancy:-

-Last menstrual period ……………………………………

-Expected date of delivery…………………………...

Chief complaint:-

-Vomiting ( ) - Dizziness ( )

-Headache ( ) - Abdominal pain ( )

-Excessive discharge ( ) - Varicose veins ( )

-Dyspnea ( ) - Blurring of vision ( )

-Backache ( ) - Heart burn ( )

-Bleeding: before 2o wks ( ) - after 2o wks ( )

-Edema: lower limb ( ) face ( ) hands ( )

-Toxemia:-Pre-eclampsia ( ) Eclampsia ( )

-Other condition: --

Investigations:-

Blood	-Hemoglobin	( )	result:
	-Blood group	( )	result
	-RH factor	( )	result
	-Wasserman	( )	result
Urine	-Sugar	( )	result
	-Albumin	( )	result

General examination:

-Blood pressure …………

- Weight…… Height…………

Appearance: Healthy ( ) Pale ( )

Flushed ( ) Tired ( )

Local examination:-

1-Breast

Areola color:

Nipple: normal ( ) flat ( ) Retracted ( ) cracked ( )

2- Abdomen

-Inspection: **-**

-linea negra ( )

-stria gravidarum ( )

-scar of previous operation ( )

-Palpation

-Level of the fundus………….. (In weeks).

-Lie………………………………………..

-Attitude…………………………………..

-Presentation…………………………..

-Position……………………………….

-*Auscultation*

-F.H.S

3- Extremities:-

-Varicose veins ( ) -edema ( )

Tetanus immunization:-

Date of 1 st dose-----------------------

Date of 2nd dose……………………..

Nursing diagnosis ---

Health Education:-

Topic	Items	H.E

Topic	Items	H.E

Topic	Items	H.E

Nursing care plan

Assessment	Nursing diagnosis	Nursing intervention	Evaluation

Assessment	Nursing diagnosis	Nursing intervention	Evaluation

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-Mother name------------------------------------ Age----------------

-Occupation--

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- Heart disease ( )

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Others (specify) ---

Family history of:

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Obstetrical history:

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-No. of still births ------------------------------

-No. of low birth weight---------------

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-Others (specify) ------------

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-Last menstrual period ………………………………

-Expected date of delivery…………………………...

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-Vomiting ( ) - Dizziness ( )

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-Excessive discharge ( ) - Varicose veins ( )

-Dyspnea ( ) - Blurring of vision ( )

-Backache ( ) - Heart burn ( )

-Bleeding: before 2o wks ( ) after 2o wks ( )

-Edema: lower limb ( ) face ( ) hands ( )

-Toxemia:-Pre-eclampsia ( ) Eclampsia ( )

-Other condition: --

Investigations:-

Blood -Hemoglobin ( ) result:

-Blood group ( ) result:

-RH factor ( ) result:

-Wasserman ( ) result:

Urine -Sugar ( ) result:

-Albumin ( ) result:

General examination:

-Blood pressure ………… Weight……

Height…………

Appearance: Healthy ( ) Pale ( )

Flushed ( ) Tired ( )

<u>Local examination</u>:-

1-Breast

areola color:

Nipple: normal ( ) flat ( ) Retracted ( ) cracked ( )

2- Abdomen

-Inspection: -

-linea negra ( )

-stria gravidarum ( )

-scar of previous operation ( )

-Palpation

-Level of the fundus………….. (In weeks).

-Lie……………………………………..

-Attitude………………………………..

-Presentation…………………………..

-Position……………………………….

-Auscultation

-F.H.S

3- Extremities:-

-Varicose veins ( ) -edema ( )

Tetanus immunization:-

Date of 1 st dose-----------------------

Date of 2nd dose……………………..

Nursing diagnosis ---

Health Education:-

Topic	Items	H.E

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Nursing care plan

Assessment	Nursing diagnosis	Nursing intervention	Evaluation

Assessment	Nursing diagnosis	Nursing intervention	Evaluation

Assessment	Nursing diagnosis	Nursing intervention	Evaluation

<u>Family planning</u>

-Date: --

-Mother name------------------------------ Age------------------

-Occupation---

-Education---

Medical history:

D. M. ( ) Hypertension ( )

Kidney disease ( ) Heart disease ( )

Anemia ( ) Others ( )

Family history of:

D. M. ( ) Hypertension ( )

Menstrual history:

-Age of menarche: ( )

-Rhythm 1- regular ( ) 2- irregular ( )

- Amount 1- scanty ( ) 2- moderate ( ) 3- heavy( )

- Duration ( ) days

- Cycle: 1) <21 days 2) 21<25 days (3) 25<30 days

4) 30 <35 days 5) >35 days

Obstetrical history:

-No. of living children--------------------------

- No. abortions-----------------------------------

- No. of still births ------------------------------

- No. of low birth weight------------------------

- Age of the youngest child---------------------

Previous complications:

- Ante partum hemorrhage Yes ( ) No ( )
- Toxemia: pre-eclampsia Yes ( ) No ( )

-Eclampsia Yes ( ) No ( )

- Polyhydramnios Yes ( ) No ( )

-Ectopic pregnancy Yes ( ) No ( )

Family planning history

-Previous use of contraceptive Yes ( ) No ( )

-Duration of use:……………………………………

-Difficulties in use:-…………………………………………

-Reason for changing the method:

………………………………………………………………

-Data related to current contraceptive method:

-Type---

-Duration--

-Problems and side effect: -----------------------------

-Health education

Topic	Item	Health education

Topic	Item	Health education

Family planning

-Date: --

-Mother name------------------------------ Age-----------------

-Occupation---

-Education---

Medical history:

D. M. ( ) Hypertension ( )

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Anemia ( ) Others ( )

Family history of:

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Menstrual history:

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-Duration of use:…………………………………………

-Difficulties in use:-…………………………………………

-Reason for changing the method:

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-Data related to current contraceptive method:

-Type--

-Duration---

-Problems and side effect: -----------------------------

-Health education

Topic	Item	Health education

Topic	Item	Health education

<u>Child Record</u>

-Name of child:

-Age **-Sex**

-**Vital signs**: T: --------------P: ---------------R---------

-Present health history:-

- Need or complaint:-
- If sick, history of present illness:-
- Onset ………………………..
- Start of medical treatment………………………..
- If late, reason for not seeking medical advice immediately:

…………………………………………………………..

- **Treatment received**:-

  1-……… Dose…… Route of administration

  2-……… Dose…… Route of administration

  3-……… Dose…… Route of administration

<u>-Pattern of feeding</u>

A- Breast:-

-Initiation:…..…………Number of feeds/day:………

-On demand ( ) Schedule ( ) Night feeds ( )

B- Bottle:-

1-Type of milk………………………

2- No. of feed/day……………………

3- Preparation of formula……………

4- Sterilization of bottle………………

C-Supplementary:-

-Age at start

- Type of food given

- Amount

Past history:-

1- Immunization received:-

Vaccine	**Date/age**	**Dose**
-B.C.G -Polio (salk-sabin)		
-D.P.T -Viral hepatitis -Polio(salk-sabin)		-First dose -Second dose -Third dose
-Measles -Vit. A capsule - Polio (salk - sabin)		

Booster (specify) - D.P.T - Polio(salk-sabin) -MMR - Vit. A capsule		

***2- History of communicable disease*:-**

1-Whooping cough Yes ( ) No ( )

2-Chicken pox Yes ( ) No ( )

3-Measles Yes ( ) No ( )

4-Mumps Yes ( ) No ( )

5-Poliomylitis Yes ( ) No ( )

6-Tuberculosis Yes ( ) No ( )

7-Meningitis Yes ( ) No ( )

8-Skin infection Yes ( ) No ( )

Other…………… ………………………….

3- History of other medical problems:-

-**Diarrhea:-**

-Frequency of attach/day……………

-Duration:……………………………

-Severity:……………………………

-Tonsillitis:-

-No .of attacks/month

-Recurrent attacks of fever:-

-Respiratory infections:-

Other……………………………………………

Nurses observations:-

1-Head:-

(a)Fontanels: - 1-**Anterior**: Closed ( ) Open ( )

2-**Posterior**: Closed ( ) Open ( )

(b)Eyes:

-Normal ( ) -Inflammation ( )

-Discharge ( ) -Squint ( )

-Wearing eye glasses ( )

(c)Nose:

-Normal ( ) -Discharge ( )

(d)Ear:

-Normal ( ) -Discharge ( )

-Respond to sound Yes ( ) No ( )

(e)Throat:

-Normal ( ) -Inflammation ( )

(f)Mouth:

-Normal ( ) -Thrush ( )

-Coated tongue ( ) -Dry lips ( )

(g)Teething:

-Upper mandible incisors (No….)

-Canine (No….)

-Molars (No….)

-Lower mandible incisors (No….)

-Canine (No…)

-Molars (No…)

2-Skin:-

-Normal ( )

-Rash ( ) -Characteristics:-……………

-Distribution:-………………

-Boils ( )

3-Cord:-

-Well formed ( ) Hernia ( )

4-Bowel movement:-

-Frequency:……………………………………………

-Color:……………………………………………….

-Odor:………………………………………………..

-Presence of blood ( ) -mucous ( )

5-Urine:

-Color ( ) - Odor ( )

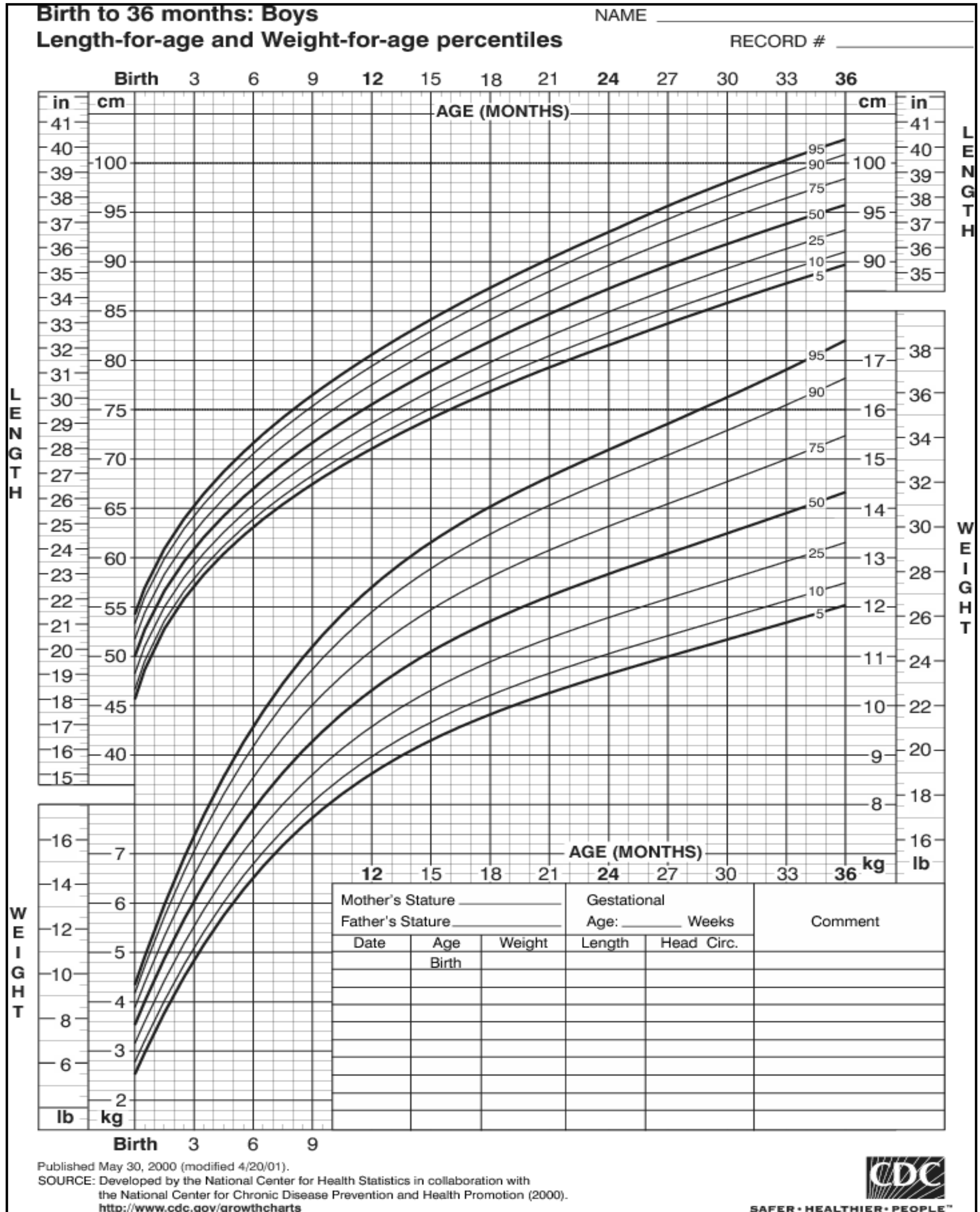
-Nursing diagnosis:-

…………………………………………………………………

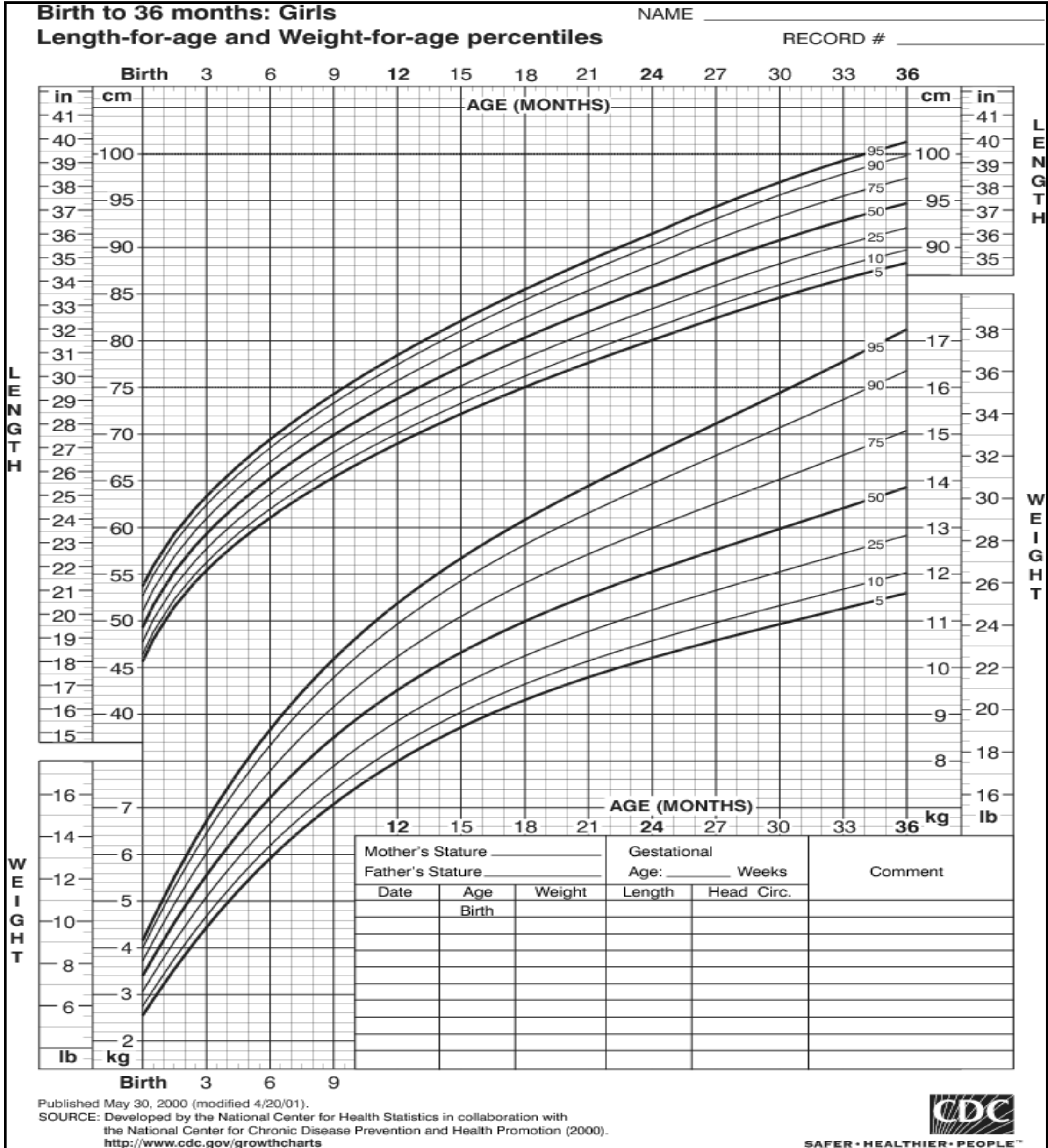
-Health education

Topic	Item	Health education

Growth chart for boy



Growth chart for girl



Child Record

-Name of child:

-Age **-Sex**

-**Vital signs**: T: -------------P: --------------R--------

-Present health history:-

- Need or complaint:-
- If sick, history of present illness:-
- Onset ………………………..
- Start of medical treatment………………………..
- If late, reason for not seeking medical advice immediately:……………………….…………
- **Treatment received**:-

  1-……… Dose…… Route of administration

  2-……… Dose…… Route of administration

  3-……… Dose…… Route of administration

-Pattern of feeding

A- Breast:-

-Initiation:…..…………Number of feeds/day:………

-On demand ( ) Schedule ( ) Night feeds ( )

B- Bottle:-

1-Type of milk……………………….

2- No. of feed/day……………………

3- Preparation of formula……………

4- Sterilization of bottle………………

C-Supplementary:-

-Age at start

- Type of food given

- Amount

Past history:-

1- Immunization received:-

Vaccine	**Date/age**	**Dose**
-B.C.G -Polio (salk-sabin)		
-D.P.T -Viral hepatitis -Polio(salk-sabin)		-First dose -Second dose -Third dose
-Measles -Vit. A capsule - Polio (salk - sabin)		

Booster (specify) - D.P.T - Polio(salk-sabin) -MMR - Vit. A capsule		

***2- History of communicable disease*:-**

1-Whooping cough Yes ( ) No ( )

2-Chicken pox Yes ( ) No ( )

3-Measles Yes ( ) No ( )

4-Mumps Yes ( ) No ( )

5-Poliomylitis Yes ( ) No ( )

6-Tuberculosis Yes ( ) No ( )

7-Meningitis Yes ( ) No ( )

8-Skin infection Yes ( ) No ( )

Other………….. ……………………….

***3- History of other medical problems*:-**

-**Diarrhea:-**

-Frequency of attach/day…………………………

-Duration:………………………………………

-Severity:………………………………………

-Tonsillitis:-

-No .of attacks/month

-Recurrent attacks of fever:-

-Respiratory infections:-

Other……………………………………………

Nurses observations:-

1-Head:-

(a)Fontanels: - 1-**Anterior**: Closed ( ) Open ( )

2-**Posterior**: Closed ( ) Open ( )

(b)Eyes:

-Normal ( ) -Inflammation ( )

-Discharge ( ) -Squint ( )

-Wearing eye glasses ( )

(c)Nose:

-Normal ( ) -Discharge ( )

(d)Ear:

-Normal ( ) -Discharge ( )

-Respond to sound Yes ( ) No ( )

(e)Throat:

-Normal ( ) -Inflammation ( )

(f)Mouth:

-Normal ( ) -Thrush ( )

-coated tongue ( ) -Dry lips ( )

(g)Teething:

-Upper mandible incisors (No….)

-Canine (No….)

-Molars (No….)

-Lower mandible incisors (No….)

-Canine (No…)

-Molars (No…)

2-Skin:-

-Normal ( )

-Rash ( ) -Characteristics:-……………

-Distribution:-………………

-Boils ( )

3-Cord:-

-Well formed ( ) Hernia ( )

4-Bowel movement:-

-Frequency:……………………………………………

-Color:……………………………………………….

-Odor:……………………………………………..

-Presence of blood ( ) -mucous ( )

5-Urine:

-Color ( ) - Odor ( )

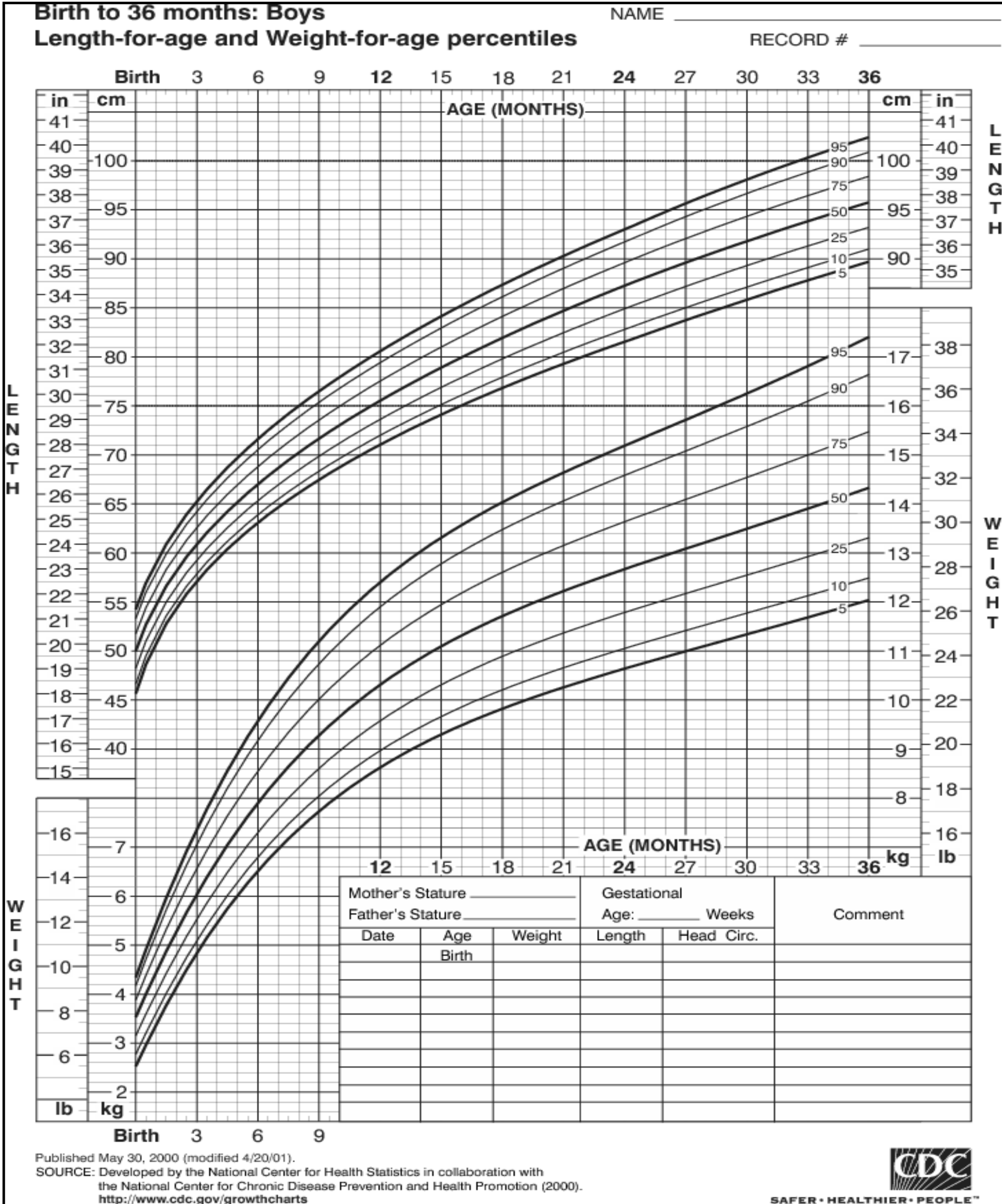
-Nursing diagnosis:-

………………………………………………………………

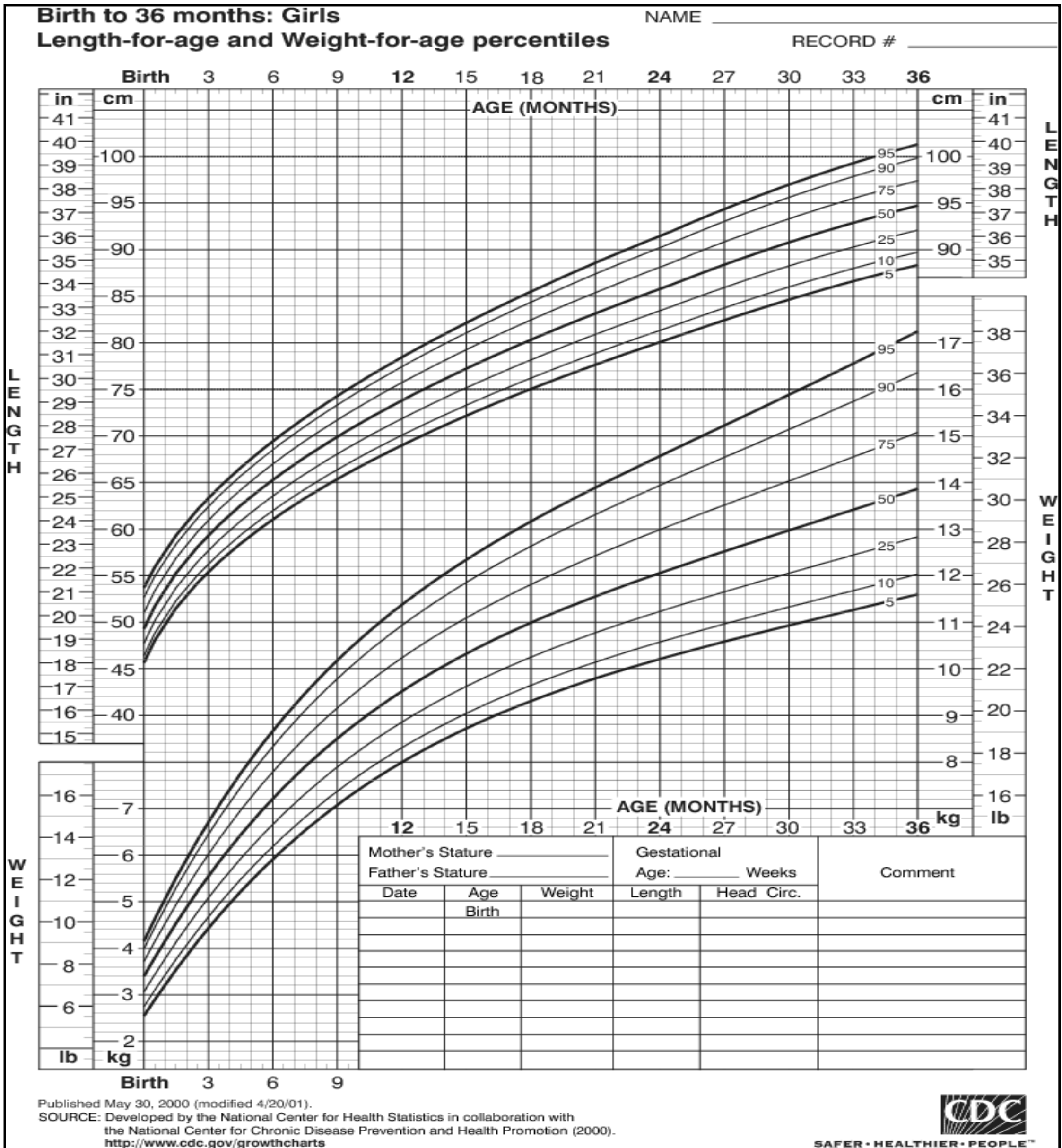
-Health education

Topic	Item	Health education

Growth chart for boy



Growth chart for girl



Home Visit Sheet

Pre visit plan

-Date of visit: **-Age:-**

-Name of client:

-Reason of visit:

-No. of visit:

Plan	Content
-History **-Present history** **-Past history** **-Medical history** **-Environment** **-Observation** **-Nursing care** **-Health education** **-Check other family member** **-Summarize the visit** **-Date of next visit**	

Pre visit plan

-Date of visit: - **-Age:-**

-Name of client:

-Reason of visit:

-No. of visit:

Plan	Content
- **Nursing care** - **Health education** - **Check other family member** **- Summarize the visit** - **Date of next visit**	

The nurse at a well-baby clinic is assessing a boy aged 24-month-old. At 21 month, the child weighted 14 kg. During this visit, the child weights 15.2 kg. Plot on the chart and write your comments.

Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

NAME ______________________

RECORD # __________

Birth 3 6 9 12 15 18 21 24 27 30 33 36

AGE (MONTHS)

in	cm		cm	in
41				41
40	100		100	40
39				39
38				38
37	95		95	37
36				36
35	90		90	35
34				
33	85			
32	80			
31				
30	75			
29				
28	70			
27				
26	65			
25				
24	60			
23				
22	55			
21				
20	50			
19				
18	45			
17				
16	40			
15				

LENGTH: 95, 90, 75, 50, 25, 10, 5

WEIGHT: 95, 90, 75, 50, 25, 10, 5

kg	lb
17	38
16	36
15	34
14	32
13	30
12	28
11	26
10	24
9	22
8	20
	18
	16

AGE (MONTHS)

12 15 18 21 24 27 30 33 36

lb	kg
16	7
14	6
12	5
10	4
8	3
6	2

Birth 3 6 9

Mother's Stature ____________ Father's Stature ____________

Gestational Age: ________ Weeks

Date	Age	Weight	Length	Head Circ.	Comment
	Birth				

Published May 30, 2000 (modified 4/20/01).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

The nurse at a well-baby clinic is assessing a girl aged 12-month. At birth, the child weighted 3.5 kg. During this visit, the child weighs 10 kg. write your conclusions about the child's weight after plotting on the chart.

Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

NAME ______________________

RECORD # ____________

Birth 3 6 9 12 15 18 21 24 27 30 33 36

AGE (MONTHS)

LENGTH (in / cm)

WEIGHT (lb / kg)

Percentiles: 95, 90, 75, 50, 25, 10, 5

Mother's Stature ______ Father's Stature ______			Gestational Age: ______ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published May 30, 2000 (modified 4/20/01).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts