NAZARETH AREA SCHOOL DISTRICT STUDENT HEALTH UPDATE 2021-2022

Student Name _____ Grade _____ Team/Teacher_____

Please complete the following to assist in providing health services at school.

A doctor signature is NOT required.

REQUIRED STATE MANDATED Dental Exam and Physical Exam

Physical Exam please give complete date _____/_____/_____ For Kindergarten/1st, 6th and 11th grades

Dental exam please give complete date _____/_____/_____ For Kindergarten/1st, 3rd and 7th grades

☐ **Allergies**

If your child requires an Epinephrine for allergies during school hours, YOU MUST provide an allergy action plan/dietary form, signed by the doctor, and the necessary medication(s) BY THE FIRST DAY OF SCHOOL

Allergic to:	Reaction:	Medication needed:	
	☐ Localized ☐ Anaphylactic	☐ Benadryl ☐ Epinephrine	
	☐ Localized ☐ Anaphylactic	☐ Benadryl ☐ Epinephrine	
	☐ Localized ☐ Anaphylactic	☐ Benadryl ☐ Epinephrine	

☐ **Asthma**

Name of Medication(s) _____

If your child requires an inhaler or nebulizer treatment for their asthma during school hours, YOU MUST provide a medication authorization form(s) and the necessary medication(s) BY THE FIRST DAY OF SCHOOL

☐ **ADD/ADHD**

Date diagnosed _____ Name of medication_____

☐ **Cardiac**

Please describe any cardiac conditions: _____

Any restrictions must be documented by a doctor yearly.

☐ **Diabetes** ☐ Type I ☐ Type II Date diagnosed _____

Insulin dependent: ☐ Yes ☐ No Insulin Pump? ☐ Yes ☐ No

**** YOU MUST provide a diabetic management plan, medication authorization form(s) and the necessary medication(s) BY THE FIRST DAY OF SCHOOL**

☐ **Seizures**

****If your child requires medication for seizures during school hours YOU MUST provide a medication authorization form(s) and the necessary medication(s) BY THE FIRST DAY OF SCHOOL**

Type of seizure ☐ Focal Onset ☐ Generalized Onset ☐ Unknown Onset

☐ Other _____

Date of last seizure_____ Medication_____

Is student currently under a doctor's care for seizures? ☐ Yes ☐ No Date last seen: _____

☐ **Bone/joint problems**

Describe _____

Any restrictions must be documented by a doctor yearly.

☐ **Mental health issues**

Diagnosis_____ Medication_____

☐ **Serious illness/injury** (please include date)

List: _____

☐ **Major and recent surgery** (please include date)

List_____

☐ **Hearing Impairment**

Describe: _____

☐ **Vision Impairment**

Describe: _____

☐ Wears glasses ☐ Wears contacts

☐ **Frequent headaches**

Are they diagnosed as migraines from a physician? ☐ Yes ☐ No

Does he/she have a treatment plan from a physician? ☐ Yes ☐ No

****If your child requires medication for frequent headaches during school hours YOU MUST provide a medication authorization form(s) and the necessary medication(s).**

☐ **Dietary restrictions/special diet** ☐ Yes ☐ No

Reason _____

***If your child requires a dietary restriction/special diet during school hours YOU MUST provide a dietary restriction form.**

<u>NEW</u> COVID-19: Confirmed Positive Test: ☐ YES ☐ NO If Yes: Date Confirmed _____

Covid-19 Vaccinations ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ None

****attach a copy of Covid -19 Vaccine Card**

Immunizations:

<u>Please attach doctor documentation of any immunizations given to your child within the past year.</u>

Medications: Please list all medications that your child takes both at home and in school.

Other: Please list any other conditions/concerns

This medical information will be kept confidential as per Family Educational Rights and Privacy Act (FERPA). Health information will be shared when there is a legitimate educational/health & safety interest.

Parent/Guardian Signature_____ ***Date***_____

Revised: 5/24/2021

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