NAZARETH AREA ELEMENTARY SCHOOLS STUDENT HEALTH UPDATE

Student Name _____ **Grade** _____

A doctor signature is NOT required.

REQUIRED STATE MANDATED Dental Exam

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

REQUIRED STATE MANDATED Physical Exam

Please have your child's doctor complete the private physical examination form (attached) at their yearly wellness visit. Send completed forms to the nurse.
Forms can also be download from the nurse's office page on your school's website

☐ **Allergies**

If your child requires Epinephrine or an antihistamine YOU MUST bring the medication and the allergy action plan signed by the doctor THE FIRST DAY OF SCHOOL

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

Immunizations: *Please attach doctor documentation of any immunizations given to your child within the past year. If they didn't receive immunizations at their 2022 yearly wellness visit documentation is not needed.*

☐ **Asthma**

Name of Medication(s) _____

If your child requires medication/inhaler 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 from your endocrinologist, medications and supplies BY THE FIRST DAY OF SCHOOL

☐ **Bone/joint problems**

Describe _____

Any restrictions must be documented by a doctor yearly.

☐ **Seizures**

If your child requires medication for seizures YOU MUST provide a seizure action plan signed by the doctor and the medication(s) BY THE FIRST DAY OF SCHOOL

Type of seizure _____ Focal Onset _____ Generalized Onset _____ Unknown Onset _____ Other _____

Date of last seizure_____ Medication_____

Is the student currently under a doctor's care for seizures? _____ Yes _____ No

If yes date last seen by the neurologist: _____

☐ **Mental health issues**

Diagnosis_____ Medication_____

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

List: _____

☐ **Frequent headaches** Are they diagnosed as migraines from a physician? ____ Yes ___ No

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

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

Describe: _____ Date: _____

Describe: _____ Date: _____

☐ **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.

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

If your child requires medication for any ailment (headaches, stomach aches etc.) YOU MUST provide a medication authorization form(s) and the necessary medication(s) to the school nurse.

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***_____