NAZARETH AREA SCHOOL DISTRICT STUDENT HEALTH UPDATE 2023-2024

Student Name _____ **Grade** _____

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)

€ **Hearing Impairment**
Describe: _____

€ **Vision Impairment**
Describe: _____
€ Wears glasses € Wears contacts

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

****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.**

Immunizations:
Please attach doctor documentation of any immunizations given to your child within the past year.

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***_____

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