NAZARETH AREA IS, MS & HS STUDENT HEALTH UPDATE 2021-2022

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: _____________

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OVER →

☐ **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.**

Optional Voluntary Submission of Covid-19 Vaccination Status: (If an individual's vaccination status affects the recommended quarantine requirement, proof of vaccination may be requested & If an individual's COVID infection history affects the recommended quarantine requirement, proof of Positive COVID infection may be requested)

COVID-19: Confirmed Positive Test: ☐ **YES** ☐ **NO** **If Yes: Date Confirmed** ________________

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

****please 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***________________