ANNUAL HEALTH UPDATE 2021-2022 Date: _____

Student Name (first/last)_____Grade_____

Has student had any serious injury, illness, hospitalization, surgery, or emergency room visit in the past 3 years? Yes_____/Dates_____ No_____

Describe_____

Outcome_____

Are there any physical conditions limiting the student's activity in school? Yes_____No_____

Describe_____

Does student use any prosthetic devices in school? (hearing aids, crutches, wheelchair, knee brace, etc.)

Yes_____No_____

Describe_____

Does the student wear glasses or contacts? Yes_____No_____

For: (circle which) distance close work astigmatism other_____

When was last eye exam?_____Doctor_____

Are there any dietary restrictions (food allergy) for your child in school? Yes_____ No_____

To what_____

Describe reaction_____

Please be advised that a doctor's note is required for the school cafeteria to provide a substitute menu item.

Does student have any chronic health condition or concern? (diabetes, epilepsy, asthma, heart problems, behavior problems, vision or hearing problems, severe allergy, seizure, high blood pressure, ADHD, ADD, tourettes, autism, cerebral palsy, depression, bi-polar, etc.) Yes_____ No_____

What is the health condition or concern?_____

_____

_____

_____

_____

What are special considerations for school? (describe: asthma triggers, activity restrictions, special diet, seizure precautions, other instructions, etc. that apply to school)

_____

_____

_____

_____

_____

List medications taken:

Name of medication(s): Dose: Time taken at home: Time taken at school:

_____

_____

_____

_____

_____

Any medication administered by school staff must have signed physician and parent authorization. All medication administered at school must be provided in its' original pharmacy labeled container, brought to school by the parent and turned in to the office staff.

Special Instruction for an Emergency: _____

_____

- *I authorize school staff to seek emergency care if and when necessary. All efforts will be made to contact parents or physician and then alternate emergency contacts. All emergency costs are at the expense of the family.*
- *Due to my child's health condition and potential risk for an emergency, I authorize the school nurse to share this information with the local volunteer emergency services as a "heads up" to emergency responders.*
- *I give consent to and authorize the PPBOCES/Peyton School District to release to Colorado HCPF information related to Medicaid eligible services that may be provided to my child as necessary, to apply for and recover partial Medicaid reimbursement*.

  Yes____ No____

FOR HEALTH ROOM ******** UPDATED EMERGENCY INFORMATION**

Please be advised that emergency care is provided by the local volunteer fire department. In the event of an emergency all efforts will be made to contact parents or physician and then alternate emergency contacts. In the event of an emergency, this information will be shared with emergency responders. All emergency costs are at the expense of the family.

Parent/Guardian name(s)_____

Address_____Phone_____

Work place-Father_____Phone_____

Work place-Mother_____Phone_____

Student's physician_____Phone_____

Alternate contact name(s)_____Phone_____

I hereby authorize school staff to obtain emergency medical care if needed and unable to contact me.

STUDENT INDIVIDUAL HEALTH SERVICES PLAN **********SPECIAL CONDITION/CONCERN

This information will be shared with school staff who are working with your child and who may have need to know. Please contact the school nurse if you have any additional concerns or information. The school nurse will contact you if additional clarification is needed. This health services plan will remain in effect for the school year or until the health status or physician's orders change. It is the responsibility of the parent to notify the school nurse whenever there is any change in the student's health status or care.

Parent Signature_____Date_____

School Nurse Signature _____ Date_____

Updated 4/27/2021