# NAZARETH AREA ELEMENTARY SCHOOLS STUDENT HEALTH UPDATE 2023-2024

**Student Name** _____ **Grade** _____

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.

**Required physical exam form:**

➔ Please keep the attached form for your physician to complete at your child's **next yearly wellness visit** (if your child went for their wellness visit in **June, July or August** please ask the doctor office to complete ASAP)

**Required dental information:**

Date of most recent dental exam _____/_____/_____ (full date please)

**Required Health update information**

Please complete this form and return it to the school nurse

**Please check a box below and sign if you checked # 3 or # 4 please complete the section below the black line**

- ☐ 1. My child does not have any medical concerns
- ☐ 2. My child's medical information and/or medication has not changed since the previously completed health update
- ☐ 3. My child is new to KNBES with medical concerns (please complete the section below
- ☐ 4. My child's health history has changed since the previously completed health update (please indicate any new medical concerns, medical changes and/or medication additions/changes/deletions in the section below)

***Parent/Guardian Signature***_____***Date***_____

***The following sections are for new enrollments and current students with medical changes and/or new medical concerns from the previously completed health update on file.***

☐ **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<br>_____ Anaphylactic | _____ Benadryl<br>_____ Epinephrine | |
| | _____ Localized<br>_____ Anaphylactic | _____ Benadryl<br>_____ Epinephrine | |

☐ **Asthma** **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**

☐ Currently prescribed medication_____

☐ **Cardiac issues:**

Please describe _____

**Any restrictions must be documented by a doctor yearly.**

☐ **Diabetes**

☐ Newly diagnosis Date of diagnosis ____/____/____

☐ Insulin changes _____

**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**

**Date of last seizure**_____

**Medications** _____

☐ **Recent trauma or injuries**

_____

***Any restrictions must be documented by a doctor***

☐ **Recent surgeries**

_____

***Any restrictions must be documented by a doctor***

☐ **Dietary restrictions**

_____

***Any restrictions must be documented by a doctor yearly.***

☐ **Migraines or frequent headaches**

☐ **Current medication** _____

☐ **Mental health issues** (please list all diagnoses)

_____

☐ **Medication changes/additions/deletions**

_____

☐ **Medication** (prescribed by your doctor daily or as needed) Please include name, dose and number of times per day)

☐ **New** _____

☐ **Discontinued** _____

☐ **Medication dose changes**_____

**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 information:** Pleaese list any other conditions or concerns you want the school nurse to be aware of below:

_____

_____

**RETURN TO THE SCHOOL NURSE**

**Student Name:** _____

**Please bring this physical examination form to your physician when your child has their yearly wellness exam. If the exam was completed in June, July or August please contact your physician to complete this form ASAP**

| Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐ | CHECK ONE: NORMAL | *ABNORMAL | DEFER | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
|---|---|---|---|---|
| Height: ( ) inches | | | | |
| Weight: ( ) pounds | | | | |
| BMI: ( ) | | | | |
| BMI-for-Age Percentile: ( ) % | | | | |
| Pulse: ( ) | | | | |
| Blood Pressure: ( / ) | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes/Vision Corrected ☐ | | | | |
| Ears/Hearing | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |
| Spine (Scoliosis) | | | | |
| Other | | | | |

| TUBERCULIN TEST | DATE APPLIED | DATE READ | RESULT/FOLLOW-UP |
|---|---|---|---|
| | | | |
| | | | |

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**

(Additional space on page 4)

**Parent/guardian present during exam: Yes ☐ No ☐**

**Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____**

**Print name of examiner** _____

**Print examiner's office address** _____ **Phone** _____

**Signature of examiner** _____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**