# Medical Update

Student Name _____ Date of Birth_____
Parent Name_____ Date of Report_____

**Please inform the School Nurse or your Family Service Coordinator of all changes in medical status.**

Medical Diagnosis _____

Primary Care Physician_____
Address_____Phone_____
Psychiatrist _____
Address_____Phone_____
Neurologist _____
Address_____Phone_____
Dentist _____
Address_____Phone_____
Other Medical Specialists _____
Address_____Phone_____

My child takes the following medications on a routine basis

| Medication | Dose | Times given | Purpose |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

My child takes the following medications on an as needed basis

| Medication | Dose | Given under these circumstances |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child exhibited any of the following (please check all that apply)

___ Date of last Tetanus vaccine_____
___ History of seizure activity (a seizure profile may be requested)
Type_____ Frequency_____
Treatment_____
Is child currently seizure active? _____Last known seizure _____
____Significant allergies
Food allergies requiring special diet_____Food sensitivities_____
Medication allergies_____Environmental _____
Other _____
____ History of ear infections ___PE Tubes currently in place (circle Right, Left, Both)
____ Asthma or chronic upper respiratory difficulties
____ History of contagious illness - please specify _____
____ Has had Chicken pox illness? _____Has had vaccine?_____
____ Glasses or corrective lenses – please specify when needed_____
____ Hearing Aids
____ Other medical condition/needs_____
____ Upcoming medical evaluations or treatments planned _____