

**CARROLL COUNTY SCHOOLS
MEDICAL UPDATE FORM**

Student: _____ Date of Birth: _____ Age: _____ Grade: _____

School: _____ Teacher: _____ Current School Services: _____

PLEASE CHECK ALL CURRENT SERVICES PROVIDED AT SCHOOL:

PHYSICAL THERAPY _____ OCCUPATIONAL THERAPY _____ SPEECH-LANGUAGE THERAPY _____

AUDIOLOGICAL SERVICES _____ NURSING SERVICES _____ OTHER: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Prognosis: _____

Medication(s) and Dosage: _____

Student's medical condition and/or treatment may cause problems with: (Please check all that apply.)

- | | | | | |
|---|-------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Attention | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Reasoning/Memory | <input type="checkbox"/> Seizures | <input type="checkbox"/> Attendance | <input type="checkbox"/> Motor Control | |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Endurance | <input type="checkbox"/> Acuity (hearing/vision) | <input type="checkbox"/> Other: _____ | |

Comments: _____

Special health care procedures/allowances, which may be required at school: (Please check all that apply.)

- | | | | | |
|--|---|--|---|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Heat Sensitivity | <input type="checkbox"/> Medication | <input type="checkbox"/> Glucose Testing | <input type="checkbox"/> Injection |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Suction | <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Catheterization | |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Dressing Changes | <input type="checkbox"/> Skin Care | <input type="checkbox"/> Tracheotomy Care | |
| <input type="checkbox"/> Special Diet | <input type="checkbox"/> Schedule Modifications | <input type="checkbox"/> Activity Restrictions | <input type="checkbox"/> Other: _____ | |

Indicate details for above procedures/allowances: _____

Other recommendations and comments: _____

STUDENT HAS MEDICAL CLEARANCE FOR:

- | | | |
|---|------------------------------|-----------------------------|
| PHYSICAL THERAPY EVALUATION AND/OR TREATMENT* | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| OCCUPATIONAL THERAPY EVALUATION AND/OR TREATMENT* | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPEECH – LANGUAGE EVALUATION AND/OR TREATMENT* | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| NURSING SERVICES EVALUATION AND/OR TREATMENT* | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| AUDIOLOGICAL EVALUATION AND/OR TREATMENT * | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

***IF SCHOOL STAFF DOCUMENTS AN EDUCATIONAL NEED**

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Please Print:

Physician's Name: _____

Address: _____

Phone: _____

Please return to:
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