Clark County School District Student Health Information for School Year ________

CCF-768
Rev. 3/15

Parent/Guardian to complete:

Student Last Name: ______________________ **First Name**: ______________________ Student #: ____________

Date of Birth: ______________________ ☐ Male ☐ Female Grade: __________ Track:__________

Parent/Guardian *(Print Name)*: ______________________ **Parent/Guardian Signature (required):** ______________________ **Date:**____________

Students may have vision, hearing or spinal (alignment of back) screening performed, based on state mandates (NRS 392.420) or because a health problem is suspected. Please notify your school nurse in writing if you do not want your child to participate in any of these screenings.

Health information will be provided to appropriate school staff members as necessary to facilitate a safe, supportive environment. Please notify the health office of any changes in your child's health.

My child has a medical, mental health, or behavioral condition that may affect his/her school day: ☐ **NO** (Z) ☐ **YES**

My child has been **diagnosed by a licensed health care provider** with the following health condition(s): (Codes in parenthesis are for clerical purposes only.)

- ☐ ADHD (J) ☐ ADD (J)
- ☐ Allergy to Medication ______________________
- ☐ Asthma (A)
- ☐ Autism (N)
- ☐ Blood Disorder (B)
- ☐ Chemical Sensitivities (Q) ______________________
- ☐ Diabetes (D) ☐ Insulin Dependent ☐ Non-Insulin Dependent
- ☐ Digestive/Urinary (UU)______________________
- ☐ Endocrine (U) ☐ Thyroid Disorder (U) ☐ Adrenal Insufficiency (U)
- ☐ Food Allergy (C) ______________________
- ☐ Genetic Disorder (F) ______________________
- ☐ Glasses/Contacts (G) ☐ Blind/Visual Impairment (V)______________________
- ☐ Hearing Loss (R) ☐ Right ☐ Left Hearing Aid (H) ☐ Right ☐ Left
- ☐ Heart Condition (T) ______________________
- ☐ Mental Health Disorder (Y) ______________________
- ☐ Neurological (N) ☐ Cerebral Palsy ☐ Muscular Dystrophy ☐ Shunt ☐ Spina Bifida
- ☐ Seizures (E) Type: ______________________ Last seizure: ____________
- ☐ Other:______________________

My child requires one or more of the following medical devices or procedures while at school. **Current licensed health care provider orders are required**:

- ☐ Catheterization (UU)
- ☐ Diabetic Care (D) Blood Sugar/Ketone Testing
- ☐ Emergency Medications (PP) ______________________
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- ☐ Epinephrine Auto-Injector (PP)
- ☐ Gastrostomy Button/Tube (GT)
- ☐ Heart Defibrillator or Pacemaker (TT)
- ☐ Insulin Pen/Pump/Syringe (D)
- ☐ Nebulizer (A)
- ☐ Tracheostomy (AA)
- ☐ Vagus Nerve Stimulator (E)
- ☐ Other: ______________________
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List all medications names, INCLUDING those given at home: ______________________

Is your child **MEDICALLY** restricted from participating in PE/Recess? ☐ No ☐ Yes If yes, provide completed **medical** documentation yearly.