Clark County School District Student Health Information for School Year _____

CCF-768
Rev. 4/18

Parent/Guardian to complete:

Student Last Name: _____ First Name: _____ ID #: _____

Date of Birth: _____ ☐ Male ☐ Female Grade: _____

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). Please notify your school nurse in writing if you do not want your child to participate in any of these screenings. This screening exemption will remain active unless revoked in writing.

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) Last episode/attack: _____
- ☐ Autism (N)
- ☐ Blood Disorder (B) _____
- ☐ Cancer (K) _____
- ☐ Chemical Sensitivities (Q) _____
- ☐ Diabetes (D) ☐ Insulin Dependent ☐ Non-Insulin Dependent
- ☐ Digestive/Urinary (UU) _____
- ☐ Endocrine (U) ☐ Thyroid Disorder (U) ☐ Adrenal Insufficiency (U)
- ☐ Food Allergy (C) _____ Type of Reaction: _____
- ☐ Genetic Disorder (F) _____
- ☐ Glasses/Contacts (G) ☐ Blind/Visual Impairment (V) _____
- ☐ Hearing Loss (R) ☐ Right ☐ Left Hearing Aid (H) ☐ Right ☐ Left
- ☐ Heart Condition (T) _____
- ☐ Life-Threatening Allergy* (P) _____
- ☐ 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 <u>while at school</u>. Current Licensed Health Care Provider orders are required:

- ☐ Catheterization (UU)
- ☐ Diabetic Care Blood Sugar/Ketone Testing (D)
- ☐ Emergency Medications (PP) _____
- ☐ Epinephrine Auto-Injector (PP)
- ☐ Gastrostomy Button/Tube (GT)
- ☐ Heart Defibrillator or Pacemaker (TT)
- ☐ Inhaler (PP)
- ☐ Insulin Pen/Pump/Syringe (D)
- ☐ Nebulizer (A)
- ☐ Tracheostomy (AA)
- ☐ Vagus Nerve Stimulator (E)
- ☐ Other: _____

* If your child requires a special diet order due to severe or life-threatening food allergy, contact the Health Office or Food Service Department for the appropriate form(s). Medical documentation from a Licensed Health Care Provider is required yearly.

List all medication 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.

CCSD
CLARK COUNTY SCHOOL DISTRICT