

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) _____
- 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: _____

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.