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.)

□ None	□ Drowsiness	□ Attention	□ Mood Swings	□ Impulsivity
	□ Reasoning/Memory	□ Seizures	□ Attendance	□ Motor Control
	□ Mobility	□ Endurance	□ Acuity (hearing/vision)	□ Other: _____

Comments: _____

_____

_____

_____

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

□ None	□ Heat Sensitivity	□ Medication	□ Glucose Testing	□ Injection
	□ Feeding Tube	□ Suction	□ Ostomy Care	□ Catheterization
	□ Respiratory Therapy	□ Dressing Changes	□ Skin Care	□ Tracheotomy Care
	□ Special Diet	□ Schedule Modifications	□ Activity Restrictions	□ Other: _____

Indicate details for above procedures/allowances: _____

_____

Other recommendations and comments: _____

_____

_____

STUDENT HAS MEDICAL CLEARANCE FOR:

PHYSICAL THERAPY EVALUATION AND/OR TREATMENT*	□ YES	□ NO
OCCUPATIONAL THERAPY EVALUATION AND/OR TREATMENT*	□ YES	□ NO
SPEECH – LANGUAGE EVALUATION AND/OR TREATMENT*	□ YES	□ NO
NURSING SERVICES EVALUATION AND/OR TREATMENT*	□ YES	□ NO
AUDIOLOGICAL EVALUATION AND/OR TREATMENT *	□ YES	□ NO

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

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

Please Print:

Physician's Name: _____

Address: _____

_____

Phone: _____

Return to:
April Bolden, RN-BSN
School Nurse
Central Elementary School
Phone: 770-832-6466
Cell: 770-842-6146
Fax: 770-830-5017