# Colorado Military Academy

STUDENT HEALTH SERVICES PLAN****** SPECIAL CONDITIONS/CONCERNS

Student Name (Last)_____(First)_____

DOB _____Male _____ Female _____Grade_____

The information will be shared with the school staff who are working with your child and who may have need to know. Please contact the School Nurse if you have any additional concerns or information. The School Nurse will contact you if additional clarification is needed. This health services plan will remain in effect for the school year or until the health status or physician's orders change**. It is the responsibility of the parent to notify the School Nurse whenever there is any change in the student's heath status or care.**

Immunizations up to date? YES____ NO_____ **PLEASE PROVIDE A PAPER COPY OF IMMUNIZATIONS TO SCHOOL NURSE NO LATER THAN AUGUST 1ST, 2018 OR YOU MAY FAX TO 719.294.6005**

Has the student had the chicken pox illness? _____ If yes, when? _____

Has the student had a severe injury or illness in the past year? Yes_____ No_____

Describe: _____

Are there any physical conditions limiting the student's activity at school? Yes_____ No_____

Describe: _____

Does the student use any prosthetic devices in school (hearing aids, crutches, wheelchair, knee brace, etc)? Yes_____ No _____ Describe: _____

Does the student wear contacts or glasses? Yes____ No_____

For: _____

When was the student's last eye exam? _____ Doctor_____

Are there any dietary restrictions for your student at school? Yes_____ No_____

Food allergy to: _____ Reaction: _____

Food allergy to: _____ Reaction: _____

Food restriction to: _____ Reaction: _____

**To complete a special diet form, go to https://www.d11.org/Page2074. Please download and complete the Medical Statement for Dietary Disability School Meal Modification form.**

Does the student have any chronic health conditions or concerns (please circle)? Diabetes Epilepsy Asthma Heart Problems Behavior Problems Vision/Hearing Problems Severe Allergy Seizures Blood Pressure ADHD ADD Tourettes Autism Cerebral Palsy Depression Bi-polar

Other/Describe_____

What are the special considerations for school? Describe: asthma triggers, activity restrictions, special diet, seizure precautions, other instructions, etc. that apply to the school.

_____

_____

Allergies to medications: _____

Reaction: _____

List of medications taken:

| Name of Medication | Dose | Condition med is taken for | When is it taken |
|---|---|---|---|
| | | | |
| | | | |
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Any medication administered by school staff or special considerations must have signed physician and parent authorization. All medication administered at school must be provided in its' original pharmacy labeled container, brought to school by the parent/guardian and turned into the office staff. In the Nurses absence, medications may be dispensed by trained and delegated school staff.

Any special instructions to handle an emergency?

_____

*I authorize school staff to seek emergency care if and when necessary. All efforts will be made to contact parent/guardian and then alternate emergency contacts.

*Due to my child's health condition and potential risk of emergency, I authorize the School Nurse to share this information with local emergency responders as a "heads up."

Parent/Guardian Print Name _____ Signature_____
Date _____

**The following is for the School Nurse to complete. Student Individual Health Services Plan**

Nursing Diagnosis _____

Intervention _____

Outcome _____

Nurse Print Name_____

Nurse Signature _____ Date _____