## Intermediate School District 917
## Annual Health Information: Medically Complex and/or DASH Program

**Student** ________________________________ **Birth Date** ______________**School Year** 2016-2017

**Summary of Student's Health:** *Please √ the following which apply to your child and provide an explanation* of when problem was first noted, type of treatment and any ongoing consideration which may presently affect your child.

- ❑ Arthritis
- ❑ Asthma
- ❑ Blood /Bleeding disorder
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Congenital Malformation
- ❑ Cognitive Impairment
- ❑ Down Syndrome
- ❑ Diabetes: Type 1 or Type 2
- ❑ Frequent Colds/Upper Respiratory Infections
- ❑ Frequent Ear Infections
- ❑ Gastrointestinal/stomach disorder
- ❑ Heart problems
- ❑ Kidney Disorder
- ❑ Meningitis
- ❑ Muscular Disorder
- ❑ Orthopedic Problem
- ❑ Surgical Procedures:
  ____________________________________
  ____________________________________
- ❑ Seizure Disorder: (Must complete seizure history/plan.)
- ❑ Ulcers
- ❑ Emotional/Behavioral Problems
  ____aggression
  ____ADHD
  ____depression
  ____oppositional
  ____obsessive compulsive
  ____school phobia
  ____self-injurious
  ____ anxiety
  ____ Other
  Please explain:
  ______________________________
  ______________________________
- ❑ Other Health Problem/s:
  ______________________________
- ❑ Ventral Peritoneal Shunt

**Annual update/changes:** ____________________________________________________________
____________________________________________________________
____________________________________________________________

**General Health / History: (√ if applies to your child)**

- ❑ Has had an accident. (i.e. broken bones, head injuries, poisoning, etc.) Explain: ________________
  ____________________________________________________________
- ❑ Hearing problems. Explain: ______________________________________________
  Date of last exam _________________ Healthcare Provider: ______________________________
- ❑ Vision problems. Explain:______________________________________________
  Date of last exam _________________ Healthcare Provider: ______________________________
- ❑ Difficulties sleeping. Explain: ______________________________________________
- ❑ Problems maintaining their body temperature. Explain: ____________________________________

**Annual update/changes:** ____________________________________________________________
____________________________________________________________
____________________________________________________________

*Allergies and immunizations:*

- ❑ *<u>Allergy to any medication</u>*. If yes, what medication: ______________________
  Describe reaction: ______________________
- ❑ *<u>Any other allergy</u>*: (i.e. food type, pollen, bee stings) List all non-medication allergies: ______________________
  ______________________
  Describe reaction: ______________________
- ❑ *<u>Sensitivity</u>*: List all sensitivities: ______________________
  ______________________
  Describe reaction: ______________________

*Immunizations:*

- ❑ Exempt from any of the childhood immunizations. Which ones: ______________________
- ❑ Immunization record up to date. List recently received immunizations (month- date-year). ______________________
  ______________________

**Annual update/changes:** ______________________

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**Neurological: (√ if applies to your child)**

- ❑ **History of a seizure disorder.**
  - ❑ **Please complete "Annual Action Plan for Student with Seizure History".**
- ❑ Has a ventral peritoneal shunt. Last evaluation date and any precautions that may be necessary for functioning shunt: ______________________
- ❑ Any other neurological treatments or conditions. What: ______________________
  and when: ______________________

**Annual update/changes:** ______________________

______________________

______________________

**Cardiac-Respiratory: (√ if applies to your child)**

- ❑ Problems with frequent upper respiratory infections. Indicate frequency and what measures helped resolve:______________________
- ❑ Requires supportive management of airway to assist breathing and/or effort (i.e. nebulization, oxygen, suctioning, postural or bronchial drainage, positioning) Explain: ______________________
  ______________________
- ❑ New or existing heart problems: ______________________

**Annual update/changes:** ______________________

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______________________

**Growth: Nutrition/Diet (√ if applies to your child)**

- ❑ On a special diet. Explain: ____________________________________________
- ❑ Requires specific preparation of foods/liquids to assist eating/drinking. (i.e. thickened liquids, pureed, ground or blended diets). Explain: ____________________________________________
- ❑ Feeding problems. Explain: ____________________________________________
- ❑ Difficulty with weight gain or loss. Explain: ____________________________________________

**Annual update/changes:** ____________________________________________

| Current Weight: | Date: | Current Height: | Date: |
|---|---|---|---|
| **Current Weight:**____________ | **Date:** _______ | **Current Height:** ____________ | **Date:** _______ |
| **Current Weight:**____________ | **Date:** _______ | **Current Height:** ____________ | **Date:** _______ |
| **Current Weight:**____________ | **Date:** _______ | **Current Height:** ____________ | **Date:** _______ |

- ❑ Evaluated for growth problems related to hormonal control. When and results: ____________________________________________
- ❑ Difficulty with gastroesophageal reflux. How managed: (i.e. Nissan fundiplication, venting, medications) ____________________________________________
- ❑ Dental problems. Explain: ____________________________________________
- ❑ Constipation related or loose stooling patterns. How managed: ____________________________________________
- ❑ Special toileting requirements: (i.e. diapering, toilet training, and assistance with personal hygiene) Explain: ____________________________________________
  - ❑ How often does your child void or urinate during night: _____ during day: _______
  - ❑ Distress or irritability w/voiding or before. ____________________________________________

**Annual update/changes:** ____________________________________________

**Musculoskeletal-Integumentary: (√ if applies to your child)**

- ❑ Has mobility aids, braces or supportive orthotics or other adaptive equipment? What are they? **(please check)**

| | | | |
|---|---|---|---|
| ❑ Arm splints | ❑ KAFO's | ❑ Feeding Equip: ____________ | ❑ Hand straps |
| ❑ Helmet | ❑ Stander: ___Prone ___Supine | ❑ Feet straps | ❑ Wheelchair |
| ❑ AFO's | | ❑ TLSO | ❑ Other: _______ |
| ❑ Hand splints | | ❑ Lap Tray/Table | |

  Please list any special concerns you have regarding the use of equipment for your child: ____________________________________________

- ❑ Has had any broken bones. Explain: ____________________________________________
- ❑ Has osteoporosis. Recommended restrictions or limitations: ____________________________________________
- ❑ Any open areas that are treated and observed for. (i.e. reoccurring rash sites, G-tube sites, pump sites) Explain: ____________________________________________
- ❑ Been treated with treatments involving medication management of spasticity. Explain: ____________________________________________
- ❑ Diagnosed with scoliosis. Treatment provided : ____________________________________________

**Annual update/changes:** ____________________________________________

**Physical Changes: (√ if applies to your child)**

- ❑ Female who has a menstrual cycle. When and how frequent? ______________________
- ❑ Requires comfort measures during menstruation. (i.e. Tylenol or rest/warmth) Explain: __________
- ❑ Sexuality concerns for your child. Explain: ______________________

**Other:**

- ❑ How do you know when your child is ill? ______________________
- ❑ What comforts your child when your child when he/she appears to be ill or when upset? __________
- ❑ Other health concerns. ______________________
- ❑ Does your child receive any support services and other special programs ***other than*** what is received at school? (i.e. out patient occupational, speech, physical therapies; personal care assistant, nursing)? Please list. ______________________

**Annual update/changes: ______________________**

**Special Health Care Procedures: (√ if applies to your child)**

- ❑ Special procedures required at school. (i.e. catheterization, tube feeding, bronchial drainage, suctioning, injections, oxygen, tracheal cares, etc.) Explain: ______________________
- ❑ When does the procedure/s need to be performed? ______________________

**As the parent/guardian or health care designee, I understand that I am responsible for reviewing this information, at least annually and to the best of my abilities will provide school with the appropriate information for my child at school.**

| **(Parent/Guardian Signature)** | **(Date)** | **(School Year)** |
|---|---|---|
| **(Parent/Guardian Signature)** | **(Date)** | **(School Year)** |
| **(Parent/Guardian Signature)** | **(Date)** | **(School Year)** |

For office use only:
Name of Staff Routing: ____________________ Date: ______________ **Please check off what was routed.**
___Student file ___ Case manager ___ 917 LSN ___Building Nurse ___Home District