Central Community School District
MEDICAL HISTORY UPDATE FORM
To Be Completed By Doctor

(This information will be utilized by the School Nurse to provide health services to students)

Student's Name_____ D.O.B._____
School:_____ Teacher/Grade_____ School Nurse_____
Weight: _____ Height: _____ Date of last appointment: _____
Health Status: Stable: _____ Unstable: _____

CURRENT DIAGNOSIS & MEDICAL STATUS (*additional information may be attached to this form)*

_____
_____
_____
_____

MEDICATIONS:_____
_____
_____

Recommendations for Student Integration into the School Setting

Activity Restrictions /Limitations: _____ _____
_____
_____

Accommodations: _____ _____
_____
_____

Nutritional /Dietary: _____
_____

Adaptive Physical Education: _____ _____
_____
_____

Physical Therapy: _____
_____

Occupational Therapy: _____
_____
_____
_____

Special Procedures: _____
_____
_____

Return To Clinic: _____

Physician's Signature_____Date_____
Print Dr.'s Name Here_____Office#_____
Address_____Fax#_____