ISBVI Medical Update Form
Academic Year 2023-2024

Name: _____ DOB:_____ Grade:_____ Gender: ☐Female ☐Male

Please check all that applies to your child. Please list on the back of the form if more room is needed.

Medical Conditions/Illness:

1. ☐Eye Condition/Vision Problems
    a. Diagnosis: _____
    b. Does your child use: ☐ Glasses ☐Contacts ☐No corrective eyewear
2. ☐Asthma
    a. If YES, does your child have a rescue inhaler? YES☐ NO☐
    b. If YES, please provide a supply of medication and an Asthma Action Plan from your health care provider.
3. ☐ Seizures. Date of last seizure: _____
    a. If YES, please provide a Seizure Action Plan from your health care provider.
    b. Does your child have emergency seizure medication YES☐ NO☐
    c. If applicable, name of emergency medication _____
4. ☐Allergies
    a. If YES, does your child experience Anaphylaxis or a severe life-threatening reaction? YES☐ NO☐
    b. Allergen: _____
    c. If an Epi-Pen is required, please provided a personal supply and provider order (this can be the prescription instructions)
    d. If YES, please provide an Anaphylaxis Action Plan from your provider.
5. ☐Cerebral Shunt
    a. If YES, which side? ☐RIGHT ☐LEFT
6. ☐Digestive disorders. Explain: _____
    a. If your child requires enteral/ G-tube feedings, please have your provider fill out a G-tube Feeding Action Plan
7. ☐Diabetes. Does your child require insulin? YES☐ NO☐
    a. If YES, please provide the name of medications: _____
8. ☐Hearing Problems
    a. If YES, does your child use hearing aids? YES☐ NO☐
9. ☐Other medical conditions that the health center should be aware of? Explain: _____
10. ☐Orthotics, Braces, Prosthetics? List: _____
11. Current medications: _____
12. Allergies (ones not listed as severe above)? _____

Past Medical History:

☐Hospitalizations. If YES, please include reason and dates: _____
☐Surgery. If YES, please include type and dates: _____

Restrictions:

☐Activity Restrictions. If YES, please explain: _____
☐Dietary Restrictions. If YES, please explain: _____

****APPLIES TO ALL STUDENTS*****

PLEASE PROVIDE A CURRENT IMMUNIZATION RECORD FROM YOUR CHILD'S PROVIDER. If your child is exempt due to religious or medical reasons. Please provide the appropriate documentation.

Parent/Guardian Signature: _____ Date: _____