

# Troup County School System

## Exceptional Educational Center

### Medical Update Form

#### **SECTION ONE: Student Information:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
School \_\_\_\_\_ Parent(s) \_\_\_\_\_  
Current Special Education Services (If none write N/A) \_\_\_\_\_

\*\*\*\*\* *The following sections should be completed by a physician.* \*\*\*\*\*

#### **SECTION TWO: General Medical Information:**

1. What is the student's diagnosis(es)?: \_\_\_\_\_

2. What is the student's prognosis?: \_\_\_\_\_

3. Should physical activity be limited?  yes  no

- If yes, please describe \_\_\_\_\_

4. Is a special diet recommended?  yes  no (If yes, please attach documentation)

5. Is the student prescribed medication(s) to treat diagnosed medical condition?  yes  no

- If yes, please list medication(s) and dosage \_\_\_\_\_

6. Description of any other medically related information pertinent to the student's symptoms, behaviors, medications, or prosthesis that should be considered in educational planning: (check all that apply)

Drowsiness  Attention  Mood Swings  Impulsivity  Reasoning/Memory

Seizures  Mobility  Motor Control  Endurance  Acuity (hearing/vision)

Attendance (extended absences from school due to health factor)  Organization

Comments: \_\_\_\_\_

7. Procedures student may need to have done at school: (check all that apply)

Feeding Tube  Suction  Ostomy care  Catheterization  Tracheotomy Care

Respiratory  Skin care  Dressing changes  Swallowing Plan  None

Explain schedule/equipment/precautions: \_\_\_\_\_

8. Other recommendations (diet, exercise, rest, heat sensitivity, etc.) and comments: \_\_\_\_\_

#### **SECTION THREE: Impact of the Diagnosis**

1. Does the medical condition cause reduced efficiency in school participation, and is it likely to affect the student's educational performance?  yes  no

2. Would attendance at school represent a major medical risk to this student?  yes  no

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

Physician's Name (Please print) \_\_\_\_\_

Physician's Address \_\_\_\_\_