Morgridge Academy

Morgridge Academy
Student Medical Evaluation 2020-2021
PHONE: 303-398-1488
FAX: 303-270-2322

Name of Child: ________________________________ DOB: ______/_____/_________

1. DIAGNOSIS: Please list all diagnoses and medications. Please indicate if medications will be given at school or at home.

Diagnosis ____

Medications:	Dose:	Route:	Frequency:	Comments

2. Please complete if child has asthma. Leave area blank if child does not have asthma diagnosis:
Asthma: ______________________ ☐ Mild ☐ Moderate ☐ Severe
a. History of Exercise induced Asthma: ☐ Mild ☐ Moderate ☐ Severe
****If child has asthma, please complete information below and include Asthma Care Plan:**
PRN: Albuterol MDI 2 puffs and/or Albuterol 2.5mg nebulizer premix vials ☐ Yes ☐ No
Or ____

Pretreatment for exercise: Albuterol MDI 2 puffs or ☐ Yes ☐ No ☐ PRN
____

3. Allergies (Food Allergies please include a Food Allergy Action Plan)
____
4. Is there a history of learning difficulties? ☐ Yes ☐ No
If yes, please explain ____
5. History of emotional/behavioral disorders? ☐ Yes ☐ No
If yes, what is current mental health diagnosis? ____
6. Individual or family psychotherapy indicated? ☐ Yes ☐ No
7. Medical adherence issues? ____
8. Influenza vaccine with parent permission? ☐ Yes ☐ No

I prescribe that the medications are to be given as listed.
I prescribe that the inhaled medications be used with an appropriate spacer.
I agree that the student may receive a dose of Acetaminophen based on student's weight once a day PRN.
I agree that the student may receive a dose of liquid antacid 10-30cc Q day PRN indigestion.
I prescribe that student may complete a normal saline nasal/sinus rinse PRN.
I am referring this student to Morgridge Academy at National Jewish Health because it is the Least Restrictive Educational Environment to manage their medical needs.
I recommend a flu shot.

____________________	____________________	____________________
Providers Phone Number	Provider's Name (please print)	Date
____________________	____________________	____________________
Provider's Fax Number	Provider's Signature	Address