



Morgridge Academy

Morgridge Academy
Student Medical Evaluation 2022-2023
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 _____

Table with 5 columns: 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