Morgridge Academy
Student Medical Evaluation 2024-2025
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. Medical adherence issues? _____

- 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 the 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 the student may complete a normal saline nasal/sinus rinse PRN.
- I support the placement at Morgridge Academy due to ongoing medical needs throughout the day
- I recommend a flu shot.

_____ _____ _____
Providers Phone Number Provider's Name (please print) Date

_____ _____ _____
Provider's Fax Number Provider's Signature Address