Chandler Unified School District #80

VP Shunt History

Student Name: _____DOB: _____

School: _____Grade: _____Date: _____

1. What is the indication for your child's shunt?

_____

2. When was your child's initial shunt surgery?

_____

3. Has the shunt been revised? ☐ No ☐ Yes If yes, when?

_____

4. What side is the shunt located on? ☐ Right ☐ Left

5. When is your child's shunt due for revision?

_____

6. Do special precautions need to be taken around magnets? ☐ No ☐ Yes

7. Physical Activity Restrictions: ☐ None

   ☐ Yes, See Activity Restriction form signed by Licensed Healthcare Provider.

8. Is there any other information about your child's shunt you would like to share with school?

_____

_____

Parent/Guardian Name (Print): _____Phone No. _____

Parent/ Guardian Signature: _____Date: _____

Revised 4/21/23.