MEDICAL MANAGEMENT PLAN PACKET

CONTENTS:

Please return all completed documents to:

Health Clerk at school site or FAX: 408.522.2241

MEDICAL MANAGEMENT PLAN / HEALTH CARE PROVIDER'S REPORT

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

To be completed by your child's primary care provider or specialist

Student: _____ Date of Birth: _____

School: _____ Grade: _____ School Year: _____

Diagnosis: _____ICD 10 Code: _____ Diagnosis Date: _____

Significant Findings: _____

Allergies: _____

Brief Medical History: _____

_____

_____

HOSPITALIZATIONS:

Has the student ever been hospitalized? : ❒ Yes ❒ No

How many times has the student been hospitalized?_____

When was the most recent hospitalization? _____

a. What was the discharge diagnosis?_____
b. Describe discharge plan (ex : *IOP, residential, PHP etc)* **Please attach**

   _____

c. If the student is still inpatient, provide expected discharge date:_____
d. Does the student have a safety plan? ❒ Yes **(please attache)** ❒ No
e. Is it safe for the student to return to school upon discharge? _____

How does the condition impact daily activities: _____

_____

Treatment/Intervention Plan: _____

_____

Prescribed Medications : ❒ Yes **(Complete Authorization for Medication on pg.3)** ❒ No

Briefly describe medication: _____

_____

Health protocols;

Sign(s) that student may need medical attention:	Steps to take to address those sign(s) present:
1)_____	1)_____
_____	_____
2)_____	2)_____
_____	_____
3)_____	3)_____
_____	_____
4)_____	4)_____

Based on your assessment, will the student need any health accommodations?(**If yes, please list**)

1)_____

2)_____

3)_____

4)_____

Can this student participate in physical education?

- ❒ Yes - Unrestricted
- ❒ Yes - Restricted / Supervised **(Complete the Physical Activity Form on pg. 5)**
- ❒ No (**Complete the Physical Activity Form on pg. 5**)

PROVIDER STAMP HERE

_____ Healthcare Provider's Name

_____ Healthcare Provider's Signature

_____ Phone

_____ Fax

_____ Date

_____ Address/City

_____ **Parent/Guardian Name**

_____ **Parent/Guardian Signature**

_____ **Date**

FOR OFFICE USE

Health Clerk : _____ **Signature:** _____ **Date:** _____/_____/_____

District Nurse: _____ **Signature:** _____ **Date:** _____/_____/ _____

FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

AUTHORIZATION FOR MEDICATION FORM

Student: ______________________________________ Date of Birth: _______________

School: ______________________________ Grade: _______ School Year: _______________

California Education Code Section 49423, notwithstanding the provisions of Section 49422 states: Any student who is required to take, during regular school hours, medication prescribed for him/her by a physician, may be assisted by the school nurse or designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement. **ALL medication, including over-the-counter medications, must be provided by parent or guardian to the school in an original container AND appropriately labeled by the pharmacist.**

TO BE COMPLETED BY PHYSICIAN

The above named student is currently under my care and receiving medication(s) for the following condition(s):

Diagnosis(es): ____________________________________ **ICD-10 code(s):** ______________________

Medication	Controlled Substance	Taken @ home/ School	Dose (mg, ml, #puffs)	Rte	Time taken	Self-Administer	Self-Carry	D/C Date
Name: Symptom to treat:	❑ No ❑ Yes	❑ Home ❑ School			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ Home ❑ School			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ Home ❑ School			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	

Please Note: Renewal of this form is required for prescription changes and at the beginning of each school year.

PROVIDER STAMP HERE

_______________________ _______________________ _______________

Provider's Name Provider's Signature Date

_______________________ _______________________ _______________

Address/City Telephone Fax

_______________________ _______________________ _______________

Parent/Guardian Name **Parent/Guardian Signature** **Date**

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL
TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Date of Birth: _____ Grade : _____

School Year: _____ /_____ School Site: _____

California Education Code Section 49423 allows the school nurse or other trained, non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the **original package or original prescription bottle with the pharmacy label attached** (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

Initial below:

_____ I authorize and hereby request that designated school personnel assist my child in taking the prescribed medication(s) (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider.

_____ I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement.

_____ I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this/these medication(s).

_____ I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

_____ _____ _____

Cell Telephone Work Phone Home phone

RECOMMENDATIONS/ACCOMMODATIONS FOR PHYSICAL ACTIVITY IN SCHOOL

Student Name: _____DOB:_____ School Year: _____

Date of Most Recent Evaluation: _____

Diagnosis: _____ ICD 10 Code:_____

Diagnosis Date: _____ Treatment Plan:_____

_____

Current Medications:_____

The following <u>recommendations</u> are guidelines for physical activity in school (SELECT ONE):

_____(1) May participate in the entire physical education program without restriction including all varsity competitive sports.

_____(2) May participate in the entire physical education program except for varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball). Less strenuous sports such as baseball and golf are acceptable at the varsity level. *All activities are acceptable during the regular physical education program.*

_____(3) May participate in the physical education program except for restriction from all varsity sports and from excessively stressful activities such as rope climbing, weight lifting, sustained running (i.e. laps) and fitness testing. Must be allowed to rest when tired.

_____(4) May participate only in mild physical education activities such as circle games, golf, and badminton.

_____(5) May participate in walking activities.

_____(6) Restricted from the entire physical education program. Please provide reason: _____

_____

Recommended accommodations: _____

_____

THESE MODIFICATIONS EXPIRE ON ____/____/____.
THE STUDENT WILL BE REEVALUATED FOR REVISION OF THESE RECOMMENDATIONS ON ____/____/____.

<u>PLEASE NOTE: MODIFICATIONS WILL EXPIRE AT THE NODIFICATION EXPIRATION DATE, STUDENT'S NEXT RE-EVALUATION DATE or AT THE CURRENT SEMESTER, WHICHEVER COMES FIRST.</u>

_____ _____ _____
Healthcare Provider Name *Signature* *Date*

_____ _____
Phone *Fax*