General Medical Conditions
Individualized Student Medical Management Plan for 20____ - 20_____ School Year

This student has a medical condition which may require special treatment or care during the school day. The information below is requested in order to assist school personnel to best meet their needs. Please attach any additional information if needed.

This section to be completed by parent

Student’s Name_________________________________________________________ DOB_________________ Age_________________

School_________________________________________________ Grade_________________ HR Teacher_________________

Significant Medical History_________________________________________________________________________________________

_________________________________________________________________________________________________________________

Allergies________________________________________________________________________________________________________

Treating Physician____________________________________ Phone_________________ Fax_________________

Parent/Guardian____________________________________________ Phone_________________

Parent/Guardian____________________________________________ Phone_________________

This section to be completed by physician

Medical Diagnosis______________________________________________________________________________________________

Current Medications: Name              Dose              Frequency              Time(s)

1. ______________________________________________________________________________________________________

2. ______________________________________________________________________________________________________

3. ______________________________________________________________________________________________________

Medications needed at school (Please include specific time or indications for medications):
____________________________________________________________________________________________________________

Treatments and or Procedures needed at school:
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Physical limitations (include circumstances under which student may require assistance):
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Assistive devices/equipment used or needed at school:
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Early signs and symptoms of illness that may necessitate absence from school:
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Circumstances in which the physician should be contacted:
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Other considerations including educational concerns:
____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Physician Signature_________________________ Date__________

Parent Signature____________________________ Date__________

School Nurse Signature________________________ Date__________ □ IHP
LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT
(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, ____________________________ (first/last name) ____________________________ (date of birth), to be given the medication or treatment listed below during the school day, including when s/he is away from school property or off school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that nonhealth professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. Only FDA-approved prescribed and over-the-counter medicines will be accepted.

Name of medication: ______________________________________________________

Reason for medication (diagnosis): _________________________________________

Dosage to be given: ____________________________ Route (mouth, injection, etc.): ____________________________

Time(s) of administration: ____________________________ Allergies: ____________________________

Beginning date: ____________________________ Ending Date: ____________________________ Amount of liquid or count of pills: ____________________________

Emergency telephone numbers:

Parent/Guardian: ____________________________________________ H: ____________ C: ____________

Parent/Guardian: ____________________________________________ H: ____________ C: ____________

Doctor's Name: ____________________________________________ Doctor's Phone Number: ____________

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall only be administered up to five calendar days without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy (see back of form).

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

__________________________ Date ____________________________ Parent/Guardian Signature
Florida Department of Health in Leon County
CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

Student's Name: ____________________________________________
DOB: ______________________________________________________
School: ____________________________________________________
School Year___________

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child’s medical condition with the following organizations:

(Please check and initial all that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
    (Name of case manager: ________________________________)
___ [X] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician ________________________________
    (Please fill in Physician name)
___ [ ] Specialist Physician ________________________________
    (Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

__________________________________________________________  ____________________________
Signature                                      Date