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 she/he is away from school property on official school business. I hereby authorize the School Board of Leon Count, 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 non-health 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 the 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 for **five calendar days** without a signed 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.

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 from 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

School Year_____

Student's Name: _____
DOB: _____
School: _____

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