Homer Rice
Administrator

Jackie Pons
Superintendent

Dear Parent/Guardian,

Your child has been identified with a medical condition that may require special attention or assistance during the 2012-2013 school year. Enclosed are important documents that need to be **completed by you and your child's health care provider.** These documents provide a guide for your child's care during the school day. The Registered Nurse assigned to your child's school will provide training to designated school personnel based on this information.

The following forms need to be completed and returned to the school health room as soon as possible:

- ☐ Health Care Provider form (completed **and** signed by your child's physician)
- ☐ Consent to Share Information (check off each applicable agency **and** add other provider if not listed)
- ☐ Medication Permission Form (completed for <u>each</u> medication taken at school)

Remember to keep copies of these documents for your records!

If you have any questions, please Leon County Health Department, School Health Division at 606-8150.

Sincerely,

Nancy Cooper, RN, BSN, NCSN

Nancy Cooper, RN, BSN, NCSN
School Health Coordinator
Leon County Health Department

Child Specific Training Log

School Year: _____

Student Name: _____ School: _____

Type of Training: _____

Date	Name/Title	RN Signature

Leon County Medical Management Plan

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.

This section to be completed by parent

Student's Name_____ **DOB**_____ **Age**_____

Significant Medical History_____

_____ **Allergies**_____

Treating Physician _____ **Phone** _____ **Fax**_____

School_____ **Grade**_____ **HR Teacher**_____

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:

1. _____
2. _____

Treatments needed at school:

1. _____
2. _____

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 requires exclusion from school:

_____

Circumstances in which the physician should be contacted:

_____

_____

Other considerations including educational concerns:

_____

_____

Physician Signature _____ **Date**_____

School Nurse Signature _____ **Date**_____

Rev 5/12

LEON COUNTY HEALTH DEPARTMENT

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 Leon County Health Department, 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] 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 of Parent/Guardian or eligible student

_____
Date