

# Medical Management Plan

## SCHOOL YEAR 2023-2024

# BLEEDING DISORDERS

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

Brief Description of bleeding disorder: \_\_\_\_\_

Medications: (Please list and note that IV medications are not given by school personnel.)

Restrictions: (Please list restrictions including physical education activities, a doctor's signature is required)

First Aid Treatment for Bleeding:

- Apply ice to the site
- Call 911
- Contact Parent/Guardian

Other: \_\_\_\_\_

*Nursing services are recommended for the care of this student during the school day.*

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

**Parent/Guardian Signature**

**Print Name**

**Date**

Is your child compliant with their current treatment regime?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Does your child function independently with medication administration?

Are there any activity restrictions for your child?

If yes, please list: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_