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| **Medical Management Plan** | | **BLEEDING DISORDERS** |
| **SCHOOL YEAR** | **2024-2025** | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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.) | |  |
|  | | |

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| --- |
| 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 Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating 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 |  | No |  |
| Does your child function independently with medication administration? | | Yes |  | No |  |
| Are there any activity restrictions for your child? | | Yes |  | No |  |
| If yes, please list: |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |
| Parent/Guardian: |  | Cell: |  |
|  |  | Work: |  |