# Medical Management Plan

# BLEEDING DISORDERS

### SCHOOL YEAR    2018-2019

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 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: _____