

# Medical Management Plan

SCHOOL YEAR 2024-2025

# 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  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: \_\_\_\_\_