Dr. Stephen Malone, Superintendent
12000 Hancock Street
Becker, MN 55308-9585
Phone: 763.261.4502
smalone@becker.k12.mn.us

Dear Parent/Guardian,

We are planning for the new school year and are aware that your child has had a significant health diagnosis in the past. To ensure we have the most accurate information to care for your child, information needs to be **updated annually.** We welcome an opportunity to further discuss your child's diagnosis with you and how we can best implement a personalized school health management plan.

☐ **My child's** _____ (print child's full name) **health problem,** _____, **is no longer a concern.** *Please sign here and return to your child's school. No additional forms needed.*

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

☐ **My child's health problem continues to be a concern.**

Please fill out the Health Management Care Plan and return to your child's school.

1. Complete the Health Management Care Plan signed by physician and parent/guardian. Please list specific needs/steps to follow when child's medical condition presents. Return to Health Services office as soon as possible, whether your child needs medication at school or not.
2. If medication(s) are required, they should be brought to Health Services by a parent in a current-labeled container provided by your pharmacy.

For questions, contact the Health Paraprofessional at your child's school, or myself at 763-261-4501, ext. 3119. We would appreciate this information to be sent back to the school as soon as possible. Thank you!

Heidi Tuorila, LSN, RN

ISD #726 School Health Services
HEALTH MANAGEMENT CARE PLAN

Physician: Please complete this page **Parent/Guardian: Please complete page 2**

Student _____ Date of Birth _____ Grade ____
School _____ Teacher _____

Physician _____
Parent/Guardian _____ H# _____ W# _____ C# _____
Parent/Guardian _____ H# _____ W# _____ C# _____

Diagnosis: _____ **Date of Diagnosis:** _____
Signs and symptoms: _____
_____

TREATMENT/ADAPTATIONS NEEDED WHILE AT SCHOOL AND ON FIELD TRIPS

List specific needs/steps to follow when child's medical condition presents (i.e. when to give medication(s), medical emergency Plan, when to call parents/guardians, etc.):

- ➔
- ➔
- ➔
- ➔
- ➔

Notify Parent if: _____
_____
Call 911 if: _____

NOTE: If student needs immediate medical attention, 911 will be called.

Medications

Medication	Strength	Dose	Time	Route	Possible Side Effects	Home	School
						☐	☐
						☐	☐
						☐	☐

TYPES OF LIMITATIONS

☐ No Limitations
☐ Physical Education (specify): _____
☐ Playground (specify): _____
☐ Machinery Operation: _____
☐ Other (specify): _____

PHYSICIAN AUTHORIZATION

I authorize the above plan to be followed at school.

Physician's Signature: _____ Physician's Printed Name: _____ Date: _____

Parent/Guardian: Please complete this page

Student _____ Date of Birth _____ School _____ Grade ____

BUS INFORMATION: The Health Paraprofessional in your child's school will inform the bus garage that your child has a health management care plan on file. If there are specific directions for your child's care while riding the bus, please notify the Transportation Director.

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/ licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick the medication(s) up from the office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION FOR ACTION PLAN

I understand that this action plan may be revoked at anytime in writing, and expires in one calendar year.
I authorize the above plan to be followed in school.

Parent/Guardian Signature _____ Date _____