Boston Public Schools Individual Collaborative Health Plan

For Students with Special Health Care Needs

To be completed by Family and Primary Care Provider

Year______

Student name:

School

Grade

Student #

DOB

PCP

Student Medical/health issue
(briefly describe/list; may attach any relevant information)

Does the student's impairment interfere with one or more major health activities?

Yes *No*

The purpose of this form is to provide ***preliminary*** *information to the school about an individual student's medical needs. It is a prerequisite for any accommodations.*

If a student has a mental or physical impairment that substantially limits one or more major life activity, he/she may have need of accommodations.

For ongoing communication to occur, both the parent(s)/guardian(s) and the primary care provider (PCP) must sign the release of medical/educational information authorization on the back of the form, as per the federal regulations concerning sharing of educational and health information.

The school nurse may need to share information with support team, food services, the classroom teacher or other staff depending on the student's needs. The family should work with the nurse to determine what needs to be shared with whom. Additional forms and PCP orders may be required, depending on the student's needs. The school nurse will facilitate this and will explain how the information is kept private.

Medications

- ❑ Medication in School

(*State regulations require parent/guardian and physician authorization of nurse administration of school medications)*

- ❑ Other Medications given at home:

Procedures: *(ie tube feeding, catheterization, glucose monitoring)*

Activity

Restrictions: (check all that apply)

- ❑ **No restrictions**
- ❑ No contact sports
- ❑ No exertion other than walking
- ❑ No exposure to cold air (such as at recess, bus stop, physical education)
- ❑ No stairs
- ❑ Other

Allergies

EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

ALLERGY TO: ______________________________

Student's Name: ____________________ D.O.B: __________ Teacher: ____________________

Asthmatic Yes ☐* No ☐ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
•MOUTH	itching & swelling of the lips, tongue, or mouth
•THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•SKIN	hives, itchy rash, and/or swelling about the face or extremities
•GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
•LUNG*	shortness of breath, repetitive coughing, and/or wheezing
•HEART*	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If ingestion is suspected, give ______________________________ (medication/dose/route) and ______________________________ immediately!
2. CALL RESCUE SQUAD: (Request epinephrine) ____________________
3. CALL: Mother ____________________ Father ____________________ or emergency contacts
4. CALL: Dr. ____________________ at ____________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

____________________ ____________ ____________________ M.D. ____________

Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. ____________________	1. ____________________ Room ________
Relation: ____________ Phone: ____________	
2. ____________________	2. ____________________ Room ________
Relation: ____________ Phone: ____________	
3. ____________________	3. ____________________ Room ________
Relation: ____________ Phone: ____________	

For children with multiple food allergies, use one form for each food. 5/95

Parent/Guardian Authorization for Medication Administration
EPIPENS
LIFE THREATENING ALLERGIC REACTION

Student's Name____________________________
Date of Birth____________________

Parent/Guardian printed name

____

Telephone Number – Home ______________________

Telephone Number – Work ______________________

Telephone Number – Emergency __________________

Other person(s) to be notified in case of medication emergency:
Name____________________________
Telephone Number ________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

____

My son/daughter has the following food or drug allergies:

____

- I give permission to have the school nurse or school personnel designated and trained by the school nurse to administer an Epi-pen to my child in the event of a life threatening allergic reaction.

_____Yes _____No (If you agree to the Epi-pen option, a plan will be developed to train the designated medication administrator in the correct way to give medication and to identify any side effects.)

Parent/guardian signature________________________________

Date ______________

Relationship to Student ________________________________

School Nurse:______________________

BOSTON PUBLIC SCHOOLS

AUTHORIZATION FOR DISPENSING MEDICATIONS IN SCHOOL

PARENT/GUARDIAN:

I request that my child ______________________________

Receive medication as prescribed in the form below.

By ______________________________
Name of Primary Care Provider

____
Signature of Parent/Guardian

Telephone Number: ____________________ Date: ____________________

PHYSICIAN:

I request that my patient receive the following medication:

Name of Student: ______________________________

Diagnosis: ______________________________

Names of Medication: ______________________________

Prescribed Dosage: ______________________________

Time to be taken during school hours: ______________________________

Expected duration of treatment: ______________________________

Possible side effects and adverse reactions: ______________________________

____

Other Recommendations: ______________________________

____

Print Name: ____________________ Clinic: ____________________

Signature: ____________________ Date: ____________________

Telephone #: ____________________ Fax #: ____________________

Parent/Guardian Authorization for Prescription Medication Administration
SELF MEDICATION

Student's Name____
Date of Birth____________________

Parent/Guardian printed name

____

Telephone Number – Home ____________________

Telephone Number – Work ____________________

Telephone Number – Emergency ________________

Other person(s) to be notified in case of medication emergency:
Name_________________________
Telephone Number ______________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

____

My son/daughter has the following food or drug allergies:

____

- I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

____Yes ____No (If you agree to self medication option, a plan will be developed to monitor that the child is taking the medication appropriately and that safety guidelines are in place for carrying a medicine in the school.)

I understand I may retrieve the medication from the school at any time, *however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.*

Parent/guardian signature_________________________________
Date______________

Relationship to Student ________________________________

Address: ____

School Nurse:_____________________

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Medical Transportation

- ❑ Door to door (child has no exercise tolerance) duration: ________________
- ❑ Corner to corner (limited exercise tolerance) duration: ________________
- ❑ Special vehicle (wheelchair)

Medical transportation is provided for medical reasons only. Children with illnesses that are in control, ie ASTHMA, do not qualify for medical transportation. Safety issues (i.e., bullies, bus stop location, walking distance, parental/guardian illness) require other solutions. Please discuss this with the school nurse.

Dietary

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a licensed physician. **Schools are not required to modify or substitute if there is not a disability.**
- BPS will try to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- BPS may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations.

Check all that apply:

- ❑ Has a **life threatening** allergy to :
- ❑ Has a disabling intolerance to:
- ❑ Has a NON disabling intolerance to:
- ❑ Request for food substitution, NON disabling, reason:

Other Adaptations:

❑ **Tutoring Plan:** *(anticipated total absence of > 2 weeks/yr. for chronic illnesses such as sickle cell, cystic fibrosis, etc.; PCP must complete DOE form :*
http://www.doe.mass.edu/sped/28mr/28r3.pdf

❑ **Access accommodations:** (i.e., bathroom, elevator, etc.; attach additional information, as needed)

Parent Authorization :

I authorize my child's school nurse to discuss my child's health management with my child's primary care provider, as needed through 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. I understand that information may be privately shared with the school team.

Name: (print)

Signature: Date:

PCP Authorization

I attest that the information provided is accurate and that I have reviewed the plan with the parent/guardian/student.

Name:

Signature:

Date: