# Medical Management Plan      BLEEDING DISORDERS
## SCHOOL YEAR    2019-2020

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: _____