ATLANTA PUBLIC SCHOOLS
Making A Difference

**Department of Student Support**
**HEALTH SERVICES**

Phone: (404)802-2674
Fax: (404)802-1608

Date: _____

Dr. _____
_____
_____
_____

**RE:** _____ (D.O.B. _____/_____/_____)

Thank you for the care you provide to our student. In preparation for the upcoming school year, the school-based educational team, nursing staff, and the family need your input and instructions to assist in the educational health planning for the student named above. Please take the time to fill out our medical packet which includes the following forms:

1. **Medical Examination Report and Health Care Management Plan** -assists in providing a detailed and comprehensive overview of child's health status and needs. Please include specific recommendations for the team relative to safety and ambulation throughout the school building.
2. ***Administration of Medication/Medical Procedures List** - used to document physician orders for routine and PRN medications, nutritional supplements and other therapeutic/assistive devices (i.e. protective helmet, walker, etc.) **(Note: Please use a separate form for each physician's order to administer medication and/or perform a procedure)**
3. **Medical Statement & Diet Prescription for Meals at School** - used to document orders for alternate nutritional supplement and dietary restrictions, substitutions or preparation.
4. **Emergency Plan** – created to guide emergency intervention for the student while in school.

All these documents will remain in effect for one school year. **A new set of documents will be required each August prior to school opening.** In the event that new orders are not received, parents have the right and responsibility to administer medications and/or perform special health procedures during the school day. Feel free to keep a blank copy of the forms so you may update them at your convenience in preparation for the next school year. Thank you for your expeditious assistance in creating the optimum learning environment for your patient/our student.

| _____ | _____ | _____ |
|---|---|---|
| School Nurse / Referring Party | School / Program Location | Phone |

***Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.**

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# MEDICAL EXAMINATION REPORT

Student's Name (Last, First, Middle) _____ Birthdate _____ Sex _____

Home Address _____ Apt. _____ City _____ State _____ Zip Code _____

Parent(s)/Guardian(s) Names(s) _____ Phone _____

School (or previous school, if not yet enrolled in APS) _____ Grade _____

Printed Name and Signature of Referring Party _____ Date _____

## TO BE COMPLETED BY THE PHYSICIAN (M.D. or D.O.)

Diagnosis/Summary of Medical History

_____

_____

_____

_____

Current Medication (if any)/Notable Side Effects

_____

_____

Check all descriptions which may interfere with this student's school functioning:

_____ Frequent absences
_____ Lack of strength
_____ Lack of vitality
_____ Lack of alertness

Limited ability to: _____ move about
_____ sit
_____ manipulate materials

Sensory impairment(s) resulting in:
_____ limited vision
_____ limited hearing
_____ limited vision and hearing

Skeletal deformities affecting: _____ ambulation
_____ posture
_____ body use

Additional information regarding this student's disabling condition

_____

_____

 Student: _____

Description of special health care or emergency procedures, if applicable:

_____

_____

_____

Surgical History: Type of Surgery Date Results

_____

_____

_____

Prognosis/Precautions:

_____

_____

_____

_____

Speech Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Occupational Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Physical Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A

Special instructions regarding physical, occupational, and/or speech therapies:

_____

_____

_____

_____

_____

If applicable, name(s) and address(es) of other physicians or medical agencies providing health care to student:

_____

_____

_____

_____

_____
Physician's Signature

_____
Physician's Name (Print or Type)

_____
Name of Clinic/Health Facility, if applicable

_____
Address

_____
Date

Return to: _____

_____

_____

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# HEALTH CARE MANAGEMENT PLAN

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Student: _____ ID: _____

School: _____ DOB: _____

Teacher: _____ Medicaid: _____

Physician: _____ Preferred Hospital: _____

## PLEASE PROVIDE SPECIFIC INSTRUCTIONS ADDRESSING THE FOLLOWING AREAS

**Description of Student's Current Medical Condition, including Relevant Medical History:**

_____

_____

_____

_____

**Transportation:** Can the student ride the school bus? (Circle One) YES NO
If yes, please describe any special assistance (personnel, equipment) or special training needed:

_____

_____

**Nursing Specific Procedures/Treatments** (Note – Board Policy allows for certain procedures/ treatments to be delegated to trained unlicensed personnel. Please document if/why procedure/treatment may only be performed by RN/LPN):

_____

_____

_____

**Special Diet:** Does the student require a special diet? (Circle One) YES NO
If yes, please list specific parameters and/or instructions (Diet Prescription form should also be completed):

_____

_____

_____

**Assistance with Activities of Daily Living:**
The student requires assistance with: (Circle all that apply) Dressing Toileting Feeding None
If assistance is required, please explain:

_____

_____

_____

**Therapy:** The student requires the following type of therapy: (Circle all that apply)
Physical Occupational Speech None
If therapy is required, please give specific orders:

_____

_____

_____

**Adaptive Physical Education:**
Are there physical limitations on activities? (Circle One) YES NO
If yes, please explain which activities the student may participate in and what the limitations are:

_____
_____
_____
_____

**Teaching:**
Do school personnel require special training to care for the student? (Circle One) YES NO
If yes, please explain what is needed:

_____
_____
_____
_____

**Monitoring:**
Does the student's health status need monitoring during the school day? (Circle One) YES NO
If yes, please explain:

_____
_____
_____
_____

**Medication:** (Administration of Medication form should also be completed)
What monitoring is needed for reactions to medication, altered mood or mental status, etc.?

_____
_____
_____
_____

**Other Treatments/Procedures (procedures that may be performed by school staff):**

_____
_____
_____

**Homebound Services / Modified School Attendance Recommendations:**
Is it necessary for the student to be educated in the home? (Circle One) YES NO
Is it necessary for the student to attend school on a partial day schedule? (Circle One) YES NO
If yes, please explain (**Referral for Homebound Services form should also be completed**; this form can be used to request intermittent services):

_____
_____
_____

Physician's Signature _____ Date _____

**If you have any questions, please call the Office of Health Services 404.802.2674**

Revised 8/16/MRG

ATLANTA PUBLIC SCHOOLS

**PLEASE COMPLETE A FORM FOR EACH MEDICATION / MEDICAL PROCEDURE**
Reference: APS Policy JGCD - Medication

# ATLANTA PUBLIC SCHOOLS
# ADMINISTRATION OF MEDICATION / MEDICAL PROCEDURES

**Student's Name**_____ **Homeroom**_____

**Birthdate**_____ **Telephone#**_____ **Emergency #**_____

**Address**_____

**Medication / Medical Procedure**_____ **Diagnosis**_____

**Starting Date of Medication / Medical Procedure** _____

**Physician's requirements of dosage / method of administration:**

_____

_____

**(Please indicate if student is responsible for self-administration and should carry medication/medical equipment**

**Student is capable and recommended to possess, and self-administer this medication / medical procedure:**

**NO**_____ **YES-Supervised**_____ **YES-Unsupervised**_____

**Time medication / medical procedure is to be provided daily**_____

**Precautions, possible side effects, interventions**_____

**Drug / Food Allergies**_____

**Termination date for administering the medication / medical procedure**_____

**Physician's Name**_____

**Physician's Address**_____

**Telephone No.**_____ **Fax No:** _____

**Physician's Signature**_____ **Date**_____

- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*
- *"Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.*

**Parent(s) / Guardian(s) Signature**_____ **Date**_____

**Principal Signature:** _____ **Date**_____

ATLANTA PUBLIC SCHOOLS
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# Atlanta Public Schools
## School Nutrition Department
## Medical Statement & Diet Prescription for Meals at Schools

This form is for students who are and are not defined as "handicapped." A handicapped person means any person who has a physical or mental impairment, which substantially limits one or more major life activities, has record of such impairments, or is regarded as having such impairments (7 CFR Part 15b and FNS Instruction 783-2). All sections of the form will need to be completed by a licensed physician if the student is diagnosed with a "handicap" per Federal law 7 CFR Part 15b and FNS Instruction 783-2 or one of the following medical authorities: physician, &/or physician assistant, nurse practitioner, registered/licensed dietitian if the student is not "handicapped," but is unable to consume food(s) because of medical or other special dietary needs. The first section ("Describe the student's handicap and the major life activity(s) affected by it") does not have to be completed by the appropriate medical authority when a student is not diagnosed "handicapped".

Student's Name: _____ DOB: _____ Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lbs ☐ kg

School: _____ Grade/Teacher: _____

Diagnosis: _____

Describe the student's *"handicap"* and the major life activities affected by it:

_____

_____

Please list any dietary restrictions or special diet:

_____

_____

Please list any allergies or food intolerances to avoid. Please indicate the child's *reaction* to this food.

_____

_____

Please list the food(s) that may be substituted in the diet:

_____

_____

**Physician recommended diet:**

_____Nothing by mouth (NPO) ***Prescription provided to family for formula supplement / Formula provided for school feeds by parent. Initial: _____**

_____By mouth (PO) Type Diet: Regular ( ) Chopped ( ) Pureed ( )

**Liquids:** Regular_____ Thickened_____ / Thickened Consistency: Nectar_____ Honey_____ Pudding_____

_____ Formula Supplement to school meal **(ORAL ONLY)**

_____ Formula G-Tube Feed

Name of Formula_____ **Substitute allowed?** Yes No **(CIRCLE ONE)**

Amount at each feeding_____

Time(s) to be fed_____

Amount of water _____CC

Amount of water to flush _____CC

**Type of G-Tube Feeding:** Bolus_____ Slow Drip_____ Pump_____ / Pump Setting: _____

**Swallow study done?** Yes No **(CIRCLE ONE)** (If yes, please attach if available and indicate Date: _____/_____/_____)

**Other information regarding the diet:** _____

_____ _____ _____ _____

**Signature of the M.D. or Authorized Medical Authority** **Address** **Telephone #** **Date**

_____ _____ _____

**Parent's Signature (*Initial formula line above)** **Date** **Telephone #**

(REVISED 08/2016)

# Food Allergy Action Plan

*Emergency Care Plan*

Place Student's Picture Here

Name: _____ D.O.B.: ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

**Extremely reactive to the following foods:** _____

**THEREFORE:**

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion:**

**One or more** of the following:

| | |
|---|---|
| LUNG: | Short of breath, wheeze, repetitive cough |
| HEART: | Pale, blue, faint, weak pulse, dizzy, confused |
| THROAT: | Tight, hoarse, trouble breathing/swallowing |
| MOUTH: | Obstructive swelling (tongue and/or lips) |
| SKIN: | Many hives over body |

Or **combination** of symptoms from different body areas:

| | |
|---|---|
| SKIN: | Hives, itchy rashes, swelling (e.g., eyes, lips) |
| GUT: | Vomiting, diarrhea, crampy pain |

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

**MILD SYMPTOMS ONLY:**

| | |
|---|---|
| MOUTH: | Itchy mouth |
| SKIN: | A few hives around mouth/face, mild itch |
| GUT: | Mild nausea/discomfort |

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

## Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

## Monitoring

***Stay with student; alert healthcare professionals and parent.*** Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature Date Physician/Healthcare Provider Signature Date

TURN FORM OVER ` Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013

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## EMERGENCY PLAN FOR STUDENT WITH SPECIAL HEALTH CARE NEEDS

***EMERGENCY PLAN / Diagnosis:*** _____

**Student:** _____ **Date:** _____

**Birthdate:** _____ **School:** _____

**Preferred Hospital in case of an emergency:** _____

*In case of serious illness / injury, the school will render first aid as prescribed by School Board Regulations while contacting the parent. If neither the parent nor the designee can be reached and the situation is very serious, the school shall telephone the County Medical Emergency Unit (9-1-1) for immediate transportation to the nearest emergency treatment hospital. **Whenever possible, the parent's hospital preference will be observed.***

**Parent Contact Info:** Name _____ Best Phone # _____

**Healthcare Provider(s):** _____ **Phone:** _____

_____ **Phone:** _____

***What is this disease / condition / disorder?***

_____

_____

| If You See This | Do This |
|---|---|
| | |

| *IF AN EMERGENCY OCCURS:* | *WHEN CALLING 9-1-1:* |
|---|---|
| 1. If the emergency is life-threatening, immediately call 9-1-1.<br>2. Stay with student or designate another adult to do so.<br>3. Call or designate someone to call the School Nurse and/or Principal. | 1. State who you are.<br>2. State where you are (street address and exact location in the building).<br>3. State problem (Note: have copy of clinic card record available to send to ER). |

***TRAINED EMERGENCY RESPONDERS:***

| | |
|---|---|
| | |
| | |

_____ _____

**Signature of Physician or Authorized Medical Authority** **Date**

**APS RN Review/Approval:** _____ **Date:** _____

I want to be able to: _____

_____

Children's
Healthcare of Atlanta
*Dedicated to All Better*

# My asthma action plan

Patient name: _____ DOB: _____

Doctor's name: _____ Signature: _____

Doctor's phone #: _____ Date: _____

| Controller medicines | How much to take | How often | Other instructions |
|---|---|---|---|
| | | ____ times per day EVERY DAY | ❑ Gargle or rinse mouth after use |
| | | ____ times per day EVERY DAY | |
| | | ____ times per day EVERY DAY | |

| Quick-relief medicines | How much to take | How often | Other instructions |
|---|---|---|---|
| | ❑ 2 puffs<br>❑ 4-6 puffs<br>❑ 1 nebulizer treatment | Take ONLY as needed (see below — starting in Yellow Zone or before excercise) | **NOTE: If you need this medicine more than 2 days a week, call your doctor.** |

*Asthma triggers (check all that apply):*

❑ Exercise ❑ Change in temperature ❑ Molds ❑ Animals ❑ Strong odors or fumes ❑ Smoke
❑ Pollens ❑ Respiratory infections ❑ Dust ❑ Strong emotions ❑ Food/Other_____

Special instructions when I am ● ***Doing well*** ○ ***Be careful*** ● ***Ask for help***

## GREEN ZONE

### Doing *well.*

- No coughing, wheezing, chest tightness, shortness of breath during the day or night
- Can go to school and play

***PREVENT*** asthma symptoms every day:

- ☐ Take my controller medicines (above) every day
- ☐ Before exercise, take_____ puff(s) of _____
- ☐ Avoid triggers that make my asthma worse (See above)

## YELLOW ZONE

### Be *careful.*

- Coughing, wheezing, chest tightness, shortness of breath
- Waking at night due to asthma symptoms
- Can do some, but not all, usual activities
- Runny nose, watery eyes



***CAUTION.*** Continue taking my controller medicines every day.

- ☐ Take _____ puffs or _____ nebulizer treatment(s) of quick relief medicine. If I am not back in the ***Green Zone*** within one hour, then I should:
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.
- ☐ Increase _____
- ☐ Add _____

## RED ZONE

### Ask for *help.*

- Very short of breath
- Continual coughing
- Skin between ribs is pulling inwards
- Difficulty speaking without running out of breath
- Quick-relief medicines have not helped
- Symptoms same or worse after 48 hours in Yellow Zone

***MEDICAL ALERT! Get help!***

- ☐ Take quick-relief medicine:____ puffs every ____ minutes and get help immediately.
- ☐ Take_____
- ☐ Call_____

If skin, fingernail or lip color is blue at any time:

***Call 911 for help or go to the nearest Emergency Department***



Always consult your child's doctor or other healthcare provider if you have any questions or concerns about the care or health of your child.
*Children's Healthcare of Atlanta at Hughes Spalding is owned by Grady Health System® and managed by HSOC, Inc. an affiliate of Children's.*