Department of Special Education / Student Support Team Compliance / Section 504
Authorization to Release Confidential Information

DATE: _____

TO: _____
Doctor's Name

_____
Address

_____
City, State, Zip

_____
Phone Fax

RE: _____ _____ _____
Last Name First Name Middle D.O.B School Attended

In order to assist in the educational / health planning and placement of the student named above, you are hereby authorized to release the following reports/information.

_____ Psycho/Educational Evaluations
_____ Section 504 Documentation
_____ Speech and Language Evaluations
_____ Audiological Report
_____ Pre-Referral Intervention Information
_____ Other _____

_____ Instructional Plans
_____ Accommodations Plans
_____ Meeting Minutes
_____ Eligibility Report
_____ Vision Report
_____ Completion of APS Medical Packet

These records should be sent to: _____

_____

- *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 for the purpose of educational / health planning.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPPA"), 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.*

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Student

ATLANTA PUBLIC SCHOOLS

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.**

ATLANTA PUBLIC SCHOOLS

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: _____
_____
_____

ATLANTA PUBLIC SCHOOLS

HEALTH CARE MANAGEMENT PLAN

ATLANTA PUBLIC SCHOOLS

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

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**_____

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

Principal Signature: _____ **Date**_____

ATLANTA PUBLIC SCHOOLS

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)

EMERGENCY PLAN FOR STUDENT WITH SPECIAL HEALTH CARE NEEDS

ATLANTA PUBLIC SCHOOLS

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. 2. Stay with student or designate another adult to do so. 3. Call or designate someone to call the School Nurse and/or Principal.	1. State who you are. 2. State where you are (street address and exact location in the building). 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:**_____