BISHOP O'GORMAN CATHOLIC SCHOOLS

HEALTH SERVICES REQUEST FORM – A
Student Medical Care Plan*

** I release school personnel from any liability in relation to the administration of medical care plans. The undersigned acknowledges that Bishop O'Gorman Catholic Schools employees have limited or no knowledge of administering medications to students, have limited knowledge regarding first aid materials, and it assumes no liability for administering health related services.*

Parents of students requesting that staff be aware of a specialized medical care plan for their child are required to complete the following information.

Student:_____ **Condition:**_____

Date of Birth:_____ **Class:** _____

Parent/Guardian:_____ **Phone:** _____

Parent/Guardian:_____ **Phone:** _____

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1. **Background:** *Share information on student condition and include relevant medication or special accommodations provided at home as part of medical care plan.*

   _____
   _____
   _____
   _____

2. **Health Information:** *Share health information that may affect the student's education.*

   _____
   _____
   _____

3. **Support to be given from school staff:** _____

   _____
   _____
   _____

4. **Indications to contact parent/guardian:** _____

   _____
   _____
   _____

5. **Special accommodations provided by school :** _____

   _____
   _____

Parent/Guardian Signature _____ **Date:** _____

Appropriate School Staff have been informed: ☐ **Yes** ☐ **No**

School Staff Signature: _____ **Date:** _____

(Reviewed 2020)