FREMONT UNION HIGH SCHOOL DISTRICT
Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

MEDICAL MANAGEMENT PLAN PACKET

CONTENTS:

1. **MEDICAL MANAGEMENT PLAN / HEALTH CARE PROVIDER'S REPORT (pgs.1-2)**
2. **AUTHORIZATION FOR MEDICATION FORM (pg.3)**
3. **PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL (pg.4)**
4. **RECOMMENDATIONS/ACCOMMODATIONS FOR PHYSICAL ACTIVITY IN SCHOOL (pg.5)**

Please return all completed documents to:

Health Clerk at school site or FAX: 408.749.8022

589 W. Fremont Avenue, PO Box F, Sunnyvale, CA 94087 | **TEL** (408) 522-2200 | **FAX** (408) 245- 2262 | **WEB** www.fuhsd.org
SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks
Revised: August 03, 2023

FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

MEDICAL MANAGEMENT PLAN / HEALTH CARE PROVIDER'S REPORT

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

To be completed by your child's primary care provider or specialist

Student: ______________________________ Date of Birth: ____________

School: ______________________ Grade: ______ School Year: ____________

Diagnosis: ____________________ICD 10 Code: __________ Diagnosis Date: ______

Significant Findings: ____

Allergies: ____

Brief Medical History: ____

____

____

HOSPITALIZATIONS:

Has the student ever been hospitalized? : ❒ Yes ❒ No

How many times has the student been hospitalized?_________________________

When was the most recent hospitalization? ______________

a. What was the discharge diagnosis?_________________________________
b. Describe discharge plan (ex : *IOP, residential, PHP etc)* **Please attach**

   ____

c. If the student is still inpatient, provide expected discharge date:____________
d. Does the student have a safety plan? ❒ Yes **(please attache)** ❒ No
e. Is it safe for the student to return to school upon discharge? ______________

How does the condition impact daily activities: _________________________________

____

Treatment/Intervention Plan: ____

____

Medication taken during regular schoolday: ❒ Yes **(Complete Authorization for Medication on pg.3)** ❒ No

Briefly describe medication: ____

____

SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks

Health protocols;

Sign(s) that student may need medical attention:	Steps to take to address those sign(s) present:
1)____________________ ______________________	1)____________________ ______________________
2)____________________ ______________________	2)____________________ ______________________
3)____________________ ______________________	3)____________________ ______________________
4)____________________	4)____________________

Based on your assessment, will the student need any health accommodations?(**If yes, please list**)

1)____
2)____
3)____
4)____

Can this student participate in physical education?

- ❒ Yes - Unrestricted
- ❒ Yes - Restricted / Supervised (**Complete the Physical Activity Form on pg. 5**)
- ❒ No (**Complete the Physical Activity Form on pg. 5**)

______________________ Healthcare Provider's Name
______________________ Healthcare Provider's Signature
______________________ Phone
______________________ Fax
______________________ Date
______________________ Address/City

______________________ **Parent/Guardian Name**
______________________ **Parent/Guardian Signature**
______________________ **Date**

FOR OFFICE USE		
Health Clerk : ______________________	**Signature:** ______________________	**Date:** ______/______/______
District Nurse: ______________________	**Signature:** ______________________	**Date:** ______/______/ ______

SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks

FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

AUTHORIZATION FOR MEDICATION FORM

Student: ______________________________ Date of Birth: ______________

School: __________________________ Grade: ______ School Year: ______________

California Education Code Section 49423, notwithstanding the provisions of Section 49422 states: Any student who is required to take, during regular school hours, medication prescribed for him/her by a physician, may be assisted by the school nurse or designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement. **ALL medication, including over-the-counter medications, must be provided by parent or guardian to the school in an original container AND appropriately labeled by the pharmacist.**

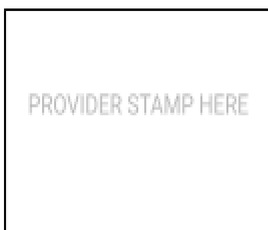
TO BE COMPLETED BY PHYSICIAN

The above named student is currently under my care and receiving medication(s) for the following condition(s):

Diagnosis(es): ______________________________ **ICD-10 code(s):** ____________________

Medication	Controlled Substance	Taken @ home only	Dose (mg, ml, #puffs)	Rte	Time taken	Self-Administer	Self-Carry	D/C Date
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	

Please Note: Renewal of this form is required for prescription changes and at the beginning of each school year.



____________________ ____________________ ____________
Provider's Name Provider's Signature Date

____________________ ____________________ ____________
Address/City Telephone Fax

____________________ ____________________ ____________
Parent/Guardian Name **Parent/Guardian Signature** **Date**

SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks

FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: ____ Date of Birth: _______________ Grade : ______

School Year: ______ /______ School Site: ____

California Education Code Section 49423 allows the school nurse or other trained, non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the **original package or original prescription bottle with the pharmacy label attached** (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

Initial below:

_______ I authorize and hereby request that designated school personnel assist my child in taking the prescribed medication(s) (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider.

_______ I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement.

_______ I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this/these medication(s).

_______ I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

______________________________ ______________________________ _______________

Parent/Guardian Name Parent/Guardian Signature Date

________________________ ________________________ ________________________

Cell Telephone Work Phone Home phone

SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks

RECOMMENDATIONS/ACCOMMODATIONS FOR PHYSICAL ACTIVITY IN SCHOOL

Student Name: ______________________________________DOB:_______________ School Year: _________

Date of Most Recent Evaluation: ____

Diagnosis: ____ ICD 10 Code:__________________

Diagnosis Date: ___________________ Treatment Plan:____

____

Current Medications:____

The following <u>recommendations</u> are guidelines for physical activity in school (SELECT ONE):

______(1) May participate in the entire physical education program without restriction including all varsity competitive sports.

______(2) May participate in the entire physical education program except for varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball). Less strenuous sports such as baseball and golf are acceptable at the varsity level. *All activities are acceptable during the regular physical education program.*

______(3) May participate in the physical education program except for restriction from all varsity sports and from excessively stressful activities such as rope climbing, weight lifting, sustained running (i.e. laps) and fitness testing. Must be allowed to rest when tired.

______(4) May participate only in mild physical education activities such as circle games, golf, and badminton.

______(5) May participate in walking activities.

______(6) Restricted from the entire physical education program. Please provide reason: ______________________

____

Recommended accommodations: ____

____

THESE MODIFICATIONS EXPIRE ON ___/___/___.
THE STUDENT WILL BE REEVALUATED FOR REVISION OF THESE RECOMMENDATIONS ON ___/___/___.

<u>PLEASE NOTE: MODIFICATIONS WILL EXPIRE AT THE NODIFICATION EXPIRATION DATE, STUDENT'S NEXT RE-EVALUATION DATE or AT THE CURRENT SEMESTER, WHICHEVER COMES FIRST.</u>

___________________________ ______________________________ __________________
Healthcare Provider Name *Signature* *Date*

___________________________ ________________________
Phone *Fax*

SUPERINTENDENT: Graham Clark | **BOARD OF TRUSTEES**: Rosa Kim, Stanley Kou, Jeff Moe, Naomi Nakano-Matsumoto,Rod Sinks