



**Carroll ISD Health Services**  
**Parental Authorization- GI Action Plan**

<b>Parent please answer:</b>	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Transportation:  Car rider  Walker  Drives self  Rides bus # \_\_\_\_\_

Before/After school activities:  Athletics  Band  Club: \_\_\_\_\_  Tutoring  Other \_\_\_\_\_

**Diagnosis/Significant Medical History:** \_\_\_\_\_

Allergies: \_\_\_\_\_

Procedures, Devices, Treatments: (Please check all that apply)

\_\_\_ Ostomy \_\_\_ Enteral Feeding \_\_\_ Central Venous Access device \_\_\_ Diet/ Dietary Restrictions

If any apply, please state details: \_\_\_\_\_

Non-pharmacologic treatments: \_\_\_\_\_

Triggers/ Precipitating Factors or Restrictions: \_\_\_\_\_

Is student able to?

- Identify and avoid food intolerances  yes  no
- Select appropriate treatments based on severity of symptoms  yes  no
- Perform bowel management program  never  sometimes  often  consistently  n/a
- Free of bowel incontinence  never  sometimes  often demonstrated  consistently demonstrated

Medication at school: \_\_\_\_\_

Nutrition and Fluid Management Needs: \_\_\_\_\_

Medical Device Needs- \_\_\_\_\_

Elimination/ Toileting Needs: \_\_\_\_\_

Physical Activity Needs/ Restrictions: \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

**I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.**

Physician- Print Name:	Physician Phone:
Parent/ Guardian Signature:	Parent/ Guardian Phone: