HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.

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PO Box 2399 · Russell Springs, KY 42642
Toll Free: 844.435.0900
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# PRIMARY CARE PROVIDER AUTHORIZATION
## Other Health Conditions

Student Name_____ Date of Birth_____ School_____

**TO BE COMPLETE HEALTHCARE PROVIDER**

Diagnosis:
__Sickle Cell Anemia
__Cystic Fibrosis
__Long QT Syndrome
__Hemophilia
__Hypertension
__Other (Specific) _____

Precautions at School_____
_____
_____
Restrictions/Exclusions at School_____
_____
_____

EMERGENCY PLAN OF ACTION
(Please include when to call parent and 911)

1. _____
2. _____
3. _____
4. If ambulance is called student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS. Parent/Guardian then assumes responsibility for student. Student may not return to school that day.
5. When student is transported via ambulance a school district staff member must meet the child at the hospital if parent or emergency contact are unable to be reached

**FORM MUST BE COMPLETED BY BOTH HEALTH CARE PROVIDER & PARENT OR GUARDIAN**

_____ _____
Printed Name of MD, APRN, or PA Address

_____ _____ _____
Signature of MD, APRN, or PA Telephone Date

**COMPLETED BY PARENT**

I understand that my signature will expressly waive any liability on behalf of the school or Healthy Kids Clinic as a result of enactment of above plan. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and School Nurse regarding my child's medical regime. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above under 'Emergency Plan of Action' to my child.

_____ _____ _____
Signature of Parent/Guardian Telephone Date

_____ _____ _____
Emergency Contact Telephone Relationship