Muscogee County School District
Student Health Services
STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____ **Date of Birth:** _____ **School year:** _____

School: _____ **Teacher:** _____ **Grade/Team:** _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Healthcare Provider:		**Phone Number:**	

Medical Diagnosis / Chronic Condition (Please describe)

_____

_____

_____

Daily Medications (List ALL daily and emergency medications):

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

8/2023
School Nurses Sharepoint Document Location: Forums > Care Plans

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Comments and Special Instructions (including school activities, sports, field trips, etc):

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____

Parent Consent for Management of Health Condition at School

I_____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County School District. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health condition management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

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