Palo Alto
Unified School District

Hemophilia Treatment Form

School Year: ____________________ School: ______________________________ Fax: ________________________

Student Name: ____________________ Grade: ______________________________ DOB: ________________________

Allergies: ____ Date of Diagnosis: ________________________

This recommend this form to be renewed annually, and if there are any changes in treatment or medication during the school year.

Physician Authorization

Specific Procedures/Plans for Bleeding Episodes:	
Any external bleeding for a cut, scrape or laceration:	
Signs of a bleeding episode: complains of tingling, bubbling pain, stiffness, or decreased motion in any limb, appears to have swelling in a body part (usually a joint) which is warm to touch, or appears to be favoring an arm or leg more than usual or limps:	
Student suffers a blow to the head, neck, or abdomen:	
Other complaints or injury:	
Typical nosebleed:	

Physician Signature

My signature below indicates I have reviewed and agree with all the recommended procedures for bleeding episodes. All procedures will be implemented in accordance with state laws and regulations. If changes are indicated, I will provide a new written form.

____ ____________

Physician Signature Date

______________________________ ______________________________

Phone Fax Clinic Stamp

Parent/Guardian Signature

I have reviewed the above information and am in agreement with the recommended procedures for bleeding episodes. I request that first aid and emergency care be provided to my child at school according to the instructions from the above health care provider. I authorize school personnel to assist with this care and I understand that trained, non-medical personnel may assist with first aid and emergency care.

______________________________________ ____________ ____________________

Parent/Guardian Signature Date Phone

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-3735 | Fax 650-833-4226