BISHOP O'GORMAN CATHOLIC SCHOOLS

HEALTH SERVICES REQUEST FORM – A

Student Medical Care Plan

Parents of students requesting that staff be aware of a specialized medical care plan for their child are required to complete the following information:

Student Name: ____________________ Condition: ____________________

Date of Birth: ____________________ Grade/Class: ____________________

Address ____________________ Phone: ____________________

1. **BACKGROUND**: *Please share information on student condition and include relevant medication or special accommodations provided at home as part of the medical care plan:*

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2. **HEALTH INFORMATION**: *Please share health information that may affect the student's education*:

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3. **SUPPORT TO BE GIVEN FROM SCHOOL STAFF**: ____________________

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4. **INDICATIONS TO CONTACT PARENT/GUARDIAN**: ____________________

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5. **SPECIAL ACCOMMODATIONS PROVIDED BY SCHOOL:** ____________________

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I. **PARENTAL RELEASE**

I release school personnel from any liability in relation to the administration of medical care plans. The undersigned acknowledges that Bishop O'Gorman Catholic School employees have limited or no knowledge of administering medications to students, have limited knowledge regarding first aid materials, and it assumes no liability for administering health related services.

Parent/Guardian Name (print):	
Parent/Guardian Signature:	Date:
Appropriate school staff have been informed: ☐ Yes ☐ No	
School Staff Signature:	Date:

(Revised 5/1/23)