



FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

MEDICAL MANAGEMENT PLAN PACKET

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- 4. RECOMMENDATIONS/ACCOMMODATIONS FOR PHYSICAL ACTIVITY IN SCHOOL (pg.5)**

Please return all completed documents to:

Health Clerk at school site or FAX: 408.522.2241



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MEDICAL MANAGEMENT PLAN / HEALTH CARE PROVIDER'S REPORT

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

To be completed by your child's primary care provider or specialist

Student: _____ Date of Birth: _____

School: _____ Grade: _____ School Year: _____

Diagnosis: _____ ICD 10 Code: _____ Diagnosis Date: _____

Significant Findings: _____

Allergies: _____

Brief Medical History: _____

HOSPITALIZATIONS:

Has the student ever been hospitalized? : Yes No

How many times has the student been hospitalized? _____

When was the most recent hospitalization? _____

a. What was the discharge diagnosis? _____

b. Describe discharge plan (ex : IOP, residential, PHP etc) **Please attach**

c. If the student is still inpatient, provide expected discharge date: _____

d. Does the student have a safety plan? Yes (**please attache**) No

e. Is it safe for the student to return to school upon discharge? _____

How does the condition impact daily activities: _____

Treatment/Intervention Plan: _____

Prescribed Medications : Yes (Complete Authorization for Medication on pg.3) No

Briefly describe medication: _____



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Health protocols;

Sign(s) that student may need medical attention:	Steps to take to address those sign(s) present:
1) _____ _____	1) _____ _____
2) _____ _____	2) _____ _____
3) _____ _____	3) _____ _____
4) _____ _____	4) _____ _____

Based on your assessment, will the student need any health accommodations?(If yes, please list)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Can this student participate in physical education?

- Yes - Unrestricted
- Yes - Restricted / Supervised (Complete the Physical Activity Form on pg. 5)
- No (Complete the Physical Activity Form on pg. 5)



Healthcare Provider's Name

Healthcare Provider's Signature

Phone

Fax

Date

Address/City

Parent/Guardian Name

Parent/Guardian Signature

Date

FOR OFFICE USE

Health Clerk : _____ Signature: _____ Date: ____/____/____

District Nurse: _____ Signature: _____ Date: ____/____/____



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AUTHORIZATION FOR MEDICATION FORM

Student's Name: _____ Date of Birth: _____ Student ID: _____

School Year: ____ / ____ School Site: _____

California Education Code Section 49423, notwithstanding the provisions of Section 49422 states: Any student who is required to take, during regular school hours, medication prescribed for him/her by a physician, may be assisted by the school nurse or designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement. **ALL medication, including over-the-counter medications, must be provided by parent or guardian to the school in an original container AND appropriately labeled by the pharmacist.**

TO BE COMPLETED BY PHYSICIAN

The above named student is currently under my care and receiving medication(s) for the following condition(s):

Diagnosis(es): _____ ICD-10 code(s): _____

Medication	Controlled Substance	Taken @	Dose (mg, ml, #puffs)	Rte	Time taken	Self-Administer	Self-Carry
Name: Symptom to treat:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Both			<input type="checkbox"/> AM Time(s): <input type="checkbox"/> PM Time(s): <input type="checkbox"/> PRN (As needed)	<input type="checkbox"/> No <input type="checkbox"/> Yes, Supervised <input type="checkbox"/> Yes, Unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes
Name: Symptom to treat:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Both			<input type="checkbox"/> AM Time(s): <input type="checkbox"/> PM Time(s): <input type="checkbox"/> PRN (As needed)	<input type="checkbox"/> No <input type="checkbox"/> Yes, Supervised <input type="checkbox"/> Yes, Unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes
Name: Symptom to treat:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Both			<input type="checkbox"/> AM Time(s): <input type="checkbox"/> PM Time(s): <input type="checkbox"/> PRN (As needed)	<input type="checkbox"/> No <input type="checkbox"/> Yes, Supervised <input type="checkbox"/> Yes, Unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes

Please Note: Renewal of this form is required for prescription changes and at the beginning of each school year.



Provider's Name

Provider's Signature

Date

Address/City

Telephone

Fax



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Student Name: _____ DOB: _____ School Year: _____

Date of Most Recent Evaluation: _____

Diagnosis: _____ ICD 10 Code: _____

Diagnosis Date: _____ Treatment Plan: _____

Current Medications: _____

The following **recommendations** are guidelines for physical activity in school (SELECT ONE):

_____ (1) May participate in the entire physical education program without restriction including all varsity competitive sports.

_____ (2) May participate in the entire physical education program except for varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball). Less strenuous sports such as baseball and golf are acceptable at the varsity level. *All activities are acceptable during the regular physical education program.*

_____ (3) May participate in the physical education program except for restriction from all varsity sports and from excessively stressful activities such as rope climbing, weight lifting, sustained running (i.e. laps) and fitness testing. Must be allowed to rest when tired.

_____ (4) May participate only in mild physical education activities such as circle games, golf, and badminton.

_____ (5) May participate in walking activities.

_____ (6) Restricted from the entire physical education program. Please provide reason: _____

Recommended accommodations: _____

THESE MODIFICATIONS EXPIRE ON ___/___/___.

THE STUDENT WILL BE REEVALUATED FOR REVISION OF THESE RECOMMENDATIONS ON ___/___/___.

PLEASE NOTE: MODIFICATIONS WILL EXPIRE AT THE MODIFICATION EXPIRATION DATE, STUDENT'S NEXT RE-EVALUATION DATE or AT THE CURRENT SEMESTER, WHICHEVER COMES FIRST.

Healthcare Provider Name

Signature

Date

Phone

Fax