



Risk for Excessive Bleeding 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 agree 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