



HEALTH CARE MANAGEMENT PLAN



Student: _____ ID: _____
School: _____ DOB: _____
Teacher: _____ Medicaid: _____
Physician: _____ Hospital: _____

PLEASE PROVIDE SPECIFIC INSTRUCTIONS ADDRESSING THE FOLLOWING AREAS

Description of Student’s Current Medical Condition, including Relevant Medical History:

Transportation: Can the student ride the school bus? (Circle One) YES NO
If yes, please describe any special assistance (personnel, equipment) or special training needed:

Nursing Specific Procedures/Treatments (Note – Board Policy allows for certain procedures / treatments to be delegated to trained unlicensed personnel. Please document if/why procedure / treatment may only be performed by RN/LPN):

Special Diet: Does the student require a special diet? (Circle One) YES NO
If yes, please list specific parameters and/or instructions (Diet Prescription form should also be completed):

Assistance with Activities of Daily Living:

The student requires assistance with: (Circle all that apply) Dressing Toileting Feeding None
If assistance is required, please explain:

Therapy: The student requires the following type of therapy: (Circle all that apply)

Physical Occupational Speech None

If therapy is required, please give specific orders: _____

Please See Reverse

Adaptive Physical Education:

Are there physical limitations on activities? (Circle One) YES NO

If yes, please explain which activities the student may participate in and what the limitations are:

Teaching:

Do school personnel require special training to care for the student? (Circle One) YES NO

If yes, please explain what is needed: _____

Monitoring:

Does the student’s health status need monitoring during the school day? (Circle One) YES NO

If yes, please explain: _____

Medication: (Administration of Medication form should also be completed)

What monitoring is needed for reactions to medication, altered mood or mental status, etc.?

Other Treatments/Procedures (procedures that may be performed by school staff):

Homebound Services / Modified School Attendance Recommendations:

Is it necessary for the student to be educated in the home? (Circle One) yes no

Is it necessary for the student to attend school on a partial day schedule? (Circle One) yes no

If yes, please explain (Referral for Homebound Services form should also be completed; this form can be used to request intermittent services):

Physician’s Signature _____ Date _____

If you have any questions, please call the Office of Health Services 404.802.2674