Medical Management Plan BLEEDING DISORDERS

SCHOOL YEAR 2024-2025

Student Name: ______________________ Date of Birth: ______________________

Physician's Name: ______________________ Phone #: ______________________

Address: ______________________ Fax #: ______________________

List Known ALLERGIES: ______________________

Brief Description of bleeding disorder: ______________________

Medications: (Please list and note that IV medications are not given by school personnel.)

Restrictions: (Please list restrictions including physical education activities, a doctor's signature is required)

First Aid Treatment for Bleeding:

- Apply ice to the site
- Call 911
- Contact Parent/Guardian

Other: ______________________

Nursing services are recommended for the care of this student during the school day.

Physicians Signature: ______________________ **Date:** ____________

PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	**Print Name**	**Date**

Is your child compliant with their current treatment regime?	Yes	☐	No	☐
Does your child function independently with medication administration?	Yes	☐	No	☐
Are there any activity restrictions for your child?	Yes	☐	No	☐

If yes, please list: ______________________

Parent/Guardian: ______________________ Cell: ______________________
Work: ______________________

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