Health Management Authorization Form

Student: _____ DOB: _____

School:_____ Date: _____

Parent Name:_____

Phone: 1._____ 2._____

****

****NOTE: Cross through any non-applicable section of this document.****

****

‡Medications at School :

Name of Medication	Indication	Dosage	Route	Time	Side Effects

****

Individual Health Management Plans (IHP):

Asthma

Signs: Short of breath, cough, vomiting, can't speak, bluish around lips, anxious, need to stand or lean forward, decreased consciousness. Other: _____

_____.

Actions: Have student use inhaler. Encourage to deep breathe and relax. **If symptoms resolve in _____ Minutes, student may return to class.**

If symptoms increase in severity, if no pulse or respirations present, or if level of consciousness decreases, **Call 911** and start CPR if needed. Call parent.

Other:_____

_____

Other Health Condition: _____

Signs: **Actions:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other: _____

_____

_____

Allergies

Allergic to:_____

_____

Signs: Wheezing, short of breath, hoarse, swelling of face or other area, bluish around lips. Other:_____

_____

Actions: Administer: _____

_____

If Epinephrine given, **Call 911 Immediately**. Call Parent.

Other:

_____

_____

_____

Seizures

Signs: Stiffening or jerking of body parts; Lips/skin bluish color; Loss of bladder or bowel control; Unconsciousness;

Other: _____

_____

Actions: Call for help; protect from injury; Loosen tight clothing;

Administer: _____

Call 911 if: 1st seizure, different or prolonged seizure pattern, repeated seizure, no breathing or pulse (start CPR), or if Diastat given and: a)Administered by non-medical staff; b)Nursing judgment indicates medical emergency based on situation and assessment; c)Parent or MD requests 911 call with seizure.

Other:_____

Release of Medical Information /Consent for Treatment/Authorization of Medications at School:

1. ‡Medications should be given at home whenever possible. Medications must comply with the Board Medication Policy. Medications may only be administered by the School Nurse or designated and trained non-medical school personnel.

2. This authorization allows for the release and exchange of information between HCDE (Hamilton County Department of Education) School Health, HCDE staff, and the listed Health Care Provider. The information provided establishes the student's treatment plan, and parental signature provides consent to implement this plan.

Parent's Signature: _____ **Date:** _____

Physician Signature: _____ **Physician phone**:_____

Physician Name or Stamp:_____**Physician Fax**: _____

Remarks: _____

School Nurse: _____ **Phone:** _____ **Fax:** _____

Health Management Authorization Form
for Supplemental Information

Page 2 (Optional) – NOTE: Page 1 must be completed and accompany this form, as it contains required signatures for consent.

Student Name: _____ School: _____

Parent Name: _____ Phone: _____ Phone: _____

Other Health Condition: _____

Signs:	**Actions:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other: _____

_____

_____

Notes

_____

_____

_____

_____

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