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: _____

Parent/Guardian: _____ Cell: _____

Work: _____