HAMILTON COUNTY DEPARTMENT OF EDUCATION
School Health
(423) 209-5458

Health Management Authorization Form

Student	Date of Birth
School	Social Security#:
Parent/Guardian Name:	DOES YOUR CHILD HAVE MEDICAID/TENNCARE? (circle one): YES NO
Day Phone: Cell Phone:	MEDICAID/TENNCARE TYPE: (circle one): BLUECARE TENNCARE SELECT AMERICHOICE AMERIGROUP
E-Mail:	TENNCARE ID#:

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 and medical assistance 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, the Health Care Provider, and for insurance billing (parents/guardians are never billed for nursing services.) Documents that may be included are: the IEP, medical records, psychological records, educational reports, and relevant test results. If your child has TennCare or becomes eligible for TennCare coverage in the future and is receiving Medicaid-reimbursable services as defined in Section 300.154 of the Individuals with Disabilities Education Act [IDEA]), the Department of Education(DOE) is authorized to seek reimbursement for these services.
3. I request payment(s) of authorized benefits be made on behalf of the insured. I understand and agree that payment(s) may be made directly to the Department of Education that is filing the Medicaid/TennCare claim for services rendered. I understand that the Department of Education is responsible for charges <u>not</u> covered by this assignment. If you do not want to give consent for DOE to submit Medicaid/TennCare claims, please initial here. _____
4. I have received notice of rights to privacy for personal health information, including HIPAA policies.

The information provided establishes the student's treatment plan, and parental and medical provider signatures provide 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

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

Student Name: _____ School: _____ Date of Birth _____

‡Medications at School: (Note: pill counts required for all controlled medications; parent or employee witness necessary.)

Name of Medication	Indication	Dosage	Route	Time	Side Effects

Individual Health Management Plans (IHP):

Asthma **Self-Carry Inhaler: Yes__ No __**

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:_____

_____

Allergies **Self-carry Treatment: Yes __ No__**

Allergic to:_____

Hx of Anaphylaxis? _____

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:

_____

_____

_____

Other Health Condition: _____

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

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:_____

****Parents must notify school if Diastat is given within 8 hours before school**_**

PILL COUNTS (All controlled medications must be counted by the school nurse on receipt. A witness, either a parent or an HCDE employee, is required.)

Medication	Dated Rec'd	Number Rec'd	Other	School Nurse Signature	Witness Signature

MEDICATION DISPOSALS (All medications not picked up by parents will be disposed of by the school, as noted in the Board Medication Policy.)

Medication	Amount Disposed	Signature	Date

NOTES:

_____

_____