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: ____

____

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Notes

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