Fayette County School Health Services

STUDENT SPECIFIC HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

Student: _____ Date of Birth: _____ School Year: 20___ - 20___

School: _____ Homeroom Teacher: _____ Grade/Team: _____

EMERGENCY CONTACTS

Parent/Guardian/Contact	***Relationship***	***Phone Number***	***Email***
Healthcare Provider:		***Phone Number:***	

MEDICAL DIAGNOSIS/CHRONIC HEALTH CONDITION:

_____

_____

EMERGENCY PLAN:

_____

_____

_____

DAILY MEDICATIONS (including daily and emergency medications):

Medication Name	***Dosage (amount)/Time***	***When To Use***	***Given at School***
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports, and trips):

_____

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____Telephone Number: _____

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's chronic health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: _____ Date: _____

Implemented: August 2001

Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006; April 13, 2012