Seminole County Public Schools Health Services

Medically Fragile Medical Management Plan
School Year _____-_____

TO BE COMPLETED BY PARENT

Student Name ________________________________ **Date of Birth** ____________

School ________________________________ **Grade** ____________

CONTACT INFORMATION

Parent/Guardian ________________________________ **Phone** Home ____________
Other ____________

Parent/Guardian ________________________________ **Phone** Home ____________
Other ____________

Physician ________________________________ **Phone** ____________
Fax ____________

TO BE COMPLETED BY PHYSICIAN

Diagnosis ________________________________

Allergies ________________________________

1. Can this student safely attend school? ❒ Yes ❒ No If **"NO"** explain why ____________
____

2. Does the student need nursing care to meet his/her medical needs? ❒ Yes ❒ No
If **"YES,"** please explain need ________________________________
____

3. List any emergency precautions/health emergencies that should be anticipated for this student ____________
____

TRANSPORTATION CONSIDERATIONS

a. Can the student safely ride a bus? ❒ Yes ❒ No If **"NO,"** explain why ____________
____

b. Is there a limited amount of time the student can safely ride the bus? ❒ Yes ❒ No
If **"YES."** explain and specify time limit (Note: riding time for students may be more than 1 hour).
____
____

c. Does the student require any medical services performed while riding the bus? (e.g. oxygen, suctioning, seizure precautions) ❒ Yes ❒ No If **"YES,"** explain ____________
____

d. Is it medically necessary for the student to ride an air conditioned bus? ❒ Yes ❒ No

e. Does the student require any adaptive equipment while riding the bus? (e.g. wheelchair lift bus)
If **"YES,"** explain ________________________________
____

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Student Name ________________________________ DOB _______________ School ______________

TREATMENTS DURING SCHOOL HOURS

Catheterization ☐ Sterile ☐ Clean intermittent
Frequency __________________________ Position ______________________________________

G Tube Feeding Formula ____________________________ Amount ______________ Time ____________

- Check one ☐ Bolus ☐ Slow drip/continuous ☐ Pump
- Will tubing be flushed with water before & after feeding? ☐ Yes ☐ No
- How much?____
- Is student allowed to have anything by mouth? ☐ Yes ☐ No
  Please specify ____

Seizure precautions ☐ Yes ☐ No If yes, complete seizure disorder care plan.

Tracheostomy Care/cleaning ☐ Yes ☐ No
Tube replacement ☐ Yes ☐ No
Suctioning ☐ Deep ☐ Surface Frequency_______________________________

Oxygen ____
____

Nebulizer ____
____

Pulse Oximeter ____
____

Ventilator ____
____

List any procedures the student has been trained to perform ___________________________________
____
____

List any limitations/precautionary measures that should be considered (e.g. physical education, outdoor activities, transporting, lifting, moving, special devices/equipment)_____________________________________
____

If medication is required during the school day, complete SCPS form 157 – Student Medication Authorization.

This Medical Management Plan is valid for this school year only unless at any time new orders are issued or current orders change as a result in change of student's condition or a hospitalization.

I give my permission for my child's doctor to be contacted if needed regarding these orders.

I understand that the above treatments will be performed by appropriate nursing personnel or non-medical school personnel as permitted by Florida Statute 1006.062. I also understand that the school is not responsible for damage/loss of equipment.

Physician Signature______________________________ Date ___________

Physician Name, Address and Telephone
(Please print or stamp)

Parent Signature ________________________________ Date ___________

School Board Nurse ______________________________ Date ___________