Established 1915 BROWARD County Public Schools

Coordinated Student Health Services

Health Condition Review

School Year 20___- 20_____

HAVE YOU COMPLETED THE ANNUAL STUDENT EMERGENCY CONTACT CARD? **Yes ❑ No ❑**

Student Last Name: _____ Student First Name: _____

Date of Birth: _____ Grade: _____

Health conditions are defined as those conditions that last 1 year or more and require ongoing medical attention, limit activities of daily living, or both.

STUDENT CARE/TRAINING

- Individual Healthcare Plan (IHCP) is a plan of action for management of actual and potential healthcare needs during the school day, on field trips, and during school-sponsored activities.
  - An IHCP may be developed for students with a *verified* health condition that requires medication, or a procedure, during the school day.
- Emergency Care Plan (ECP) is a step by step set of instructions for what to do in an emergency.
  - An ECP may be developed for students with a potential risk of emergency (i.e., anaphylaxis, seizure, diabetes, asthma).
- As permissible by the Family Educational Rights and Privacy Act (FERPA),health condition information on an ECP will be shared with applicable school staff.
- All conditions must have a documented provider diagnosis except ADD/ADHD, allergies non-life threatening, mental/behavioral health conditions and "others".

Health Condition:

ONLY check current health conditions. *Indicates conditions that **require** written documentation of diagnosis from a healthcare provider.

- ❑ ADD/ADHD (Attention Deficit / Hyperactivity)
- ❑ Allergies – nonlife threatening (not severe)
- ❑ Allergies – life threatening (severe)*
- ❑ Asthma*
- ❑ Bleeding Disorder*
- ❑ Cancer*
- ❑ Cardiac Conditions*
- ❑ Cystic fibrosis*
- ❑ Diabetes – Type 1*
- ❑ Diabetes – Type 2*
- ❑ Epilepsy / Seizure disorders*
- ❑ Kidney disorders*
- ❑ Lupus*
- ❑ Sickle cell disease*
- ❑ No current health condition
- ❑ Other

_____

_____

_____

Date of diagnosis: _____

Signs and symptoms (if any): _____

Triggers/Allergens (if any): _____

Recent hospitalization related to diagnosis? **Yes ❑ No ❑** Date: _____

Recent surgery related to diagnosis? **Yes ❑ No ❑** Date: _____

Activity restriction in school? **Yes ❑ No ❑**

Additional information ***(including known student-specific side effects to medication)***:

_____

_____

Medication Needs Assessment:

Is it medically necessary for your child to receive medication during the school day?

Yes ❑ No ❑

If **Yes**, an Authorization for Medication/Treatment Form completed by a healthcare provider must be submitted for medication administration (www.browardschools.com/healthforms).

Is the student currently taking medication that would be required for an offsite school related or school sponsored activity (including overnight trips) that occur outside of traditional school hours?

Yes ❑ No ❑

Per Florida Statute 1002.20 and School Board Policy 6305, self-carry of student medication is allowed for Metered Dose Inhaler (MDI), epinephrine autoinjector, diabetic supplies and medication, and/or pancreatic enzyme supplements with an Authorization for Medication/Treatment Form completed by a healthcare provider stating that the student is trained and independent.

Does student self-carry ANY medication? **Yes ❑ No ❑**
If yes, list the medication: _____

Please provide the best contact information, including name and number, for school staff to refer to when communicating about your child's health condition.

Parent/Guardian (Print Name): _____ Best Contact Phone Number: _____

Parent/Guardian (Signature): _____ Relationship to Student: _____

**********CLINIC USE ONLY**********

PARENT / HEALTHCARE STAFF COMMUNICATION:

Date/Time:_____Medication Authorization Form ❑ Emergency Contact Card ❑ Unable to reach parent/guardian ❑ Letter sent home ❑

Date/Time:_____Medication Authorization Form ❑ Emergency Contact Card ❑ Unable to reach parent/guardian ❑ Letter sent home ❑

Date/Time:_____Medication Authorization Form ❑ Emergency Contact Card ❑ Unable to reach parent/guardian ❑ Letter sent home ❑

Date/Time:_____No verified health condition [Remove from School Application] ❑ Referral (Admin, Social Work, Food & Nutrition, etc.) ❑

The signature below serves as an annual health record review:

RN Name: _____ RN Signature: _____ Date: _____

❑ Student needs IHP only ❑ Student needs IHP and ECP ❑ No plan required at this time