Muscogee County School District
Student Health Services
POST OPERATIVE STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Primary Healthcare Provider:		**Phone Number:**	
Surgeon:		**Phone Number:**	

Procedures/Operations: _____

Date of Procedure/Operation: _____ Date Student May Return to School: _____

Activity Level During School:

- ☐ Non-Weight bearing:
  How Long _____
- ☐ Weight Bearing for transfer/pivot only:
  How long _____
- ☐ Weight bearing to tolerance:
  How Long _____
- ☐ Partial Weight bearing:
  How Long _____
- ☐ Full Weight bearing

Assistive Devices to be Used at School:

- ☐ Wheelchair
- ☐ Walking device
- ☐ Crutches
- ☐ Orthotics: _____
- ☐ Other: _____

Child currently receives the following services at school:

- ☐ PT
- ☐ OT

May these services be continued during recovery:

- ☐ Yes If yes, restrictions: _____
- ☐ No

Additional Recommendations: _____

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Pain Management

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

COMMENTS/SPECIAL INSTRUCTIONS (including school activities, sports, field trips, etc):

_____

_____

_____

_____

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____Phone Number: _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian Consent for Management of Health Condition at School

I_____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's 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 Portable 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 Muscogee County School District. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature:_____**Date**:_____