Grace Education Academy

STUDENT MEDICAL CONDITION NOTIFICATION

GENERIC

Dear Parent,

The school records indicate that your child _____ has been

diagnosed with the following medical condition(s):

_____

_____

In order to prepare the staff for a possible emergency concerning your child, the school staff must be made aware of your child's medical condition. Therefore, the school is asking for your permission to confidentially notify the teachers and/or staff members and/or transportation of your child's condition, in order to protect your rights, your child's safety and comply with Florida Statute 1002.22 and 381.0056. The school understands this can be a sensitive situation and assures you that this information will be kept as confidential as possible.

Sincerely,

_____

Principal

_____School

PLEASE SIGN AND RETURN TO YOUR CHILD'S SCHOOL

I hereby give permission for confidential written notification to your staff of my child's medical condition.

Parent Signature: _____ Date: _____

GRACE EDUCATION ACADEMY

GENERIC MEDICAL CARE PLAN

School_____Student ID #_____

Student Name_____ DOB _____/_____/_____Date_____

Parent/GuardianName_____Phone:home_____

Work_____

cell_____

Emergency Contact _____ Phone:_____

Physician's name: _____ Phone:_____

My child's Medical Condition/Concern is _____

_____

_____

My child has had this condition/concern for _____

(length of time)

Are medications required to control the above mentioned medical condition/concern? ___YES ___NO

Name of medication: _____

(If medication is necessary at school please contact the clinic personnel for proper medication forms).
NOTE: No over the counter medication will be administered at school. A Physician must prescribe medication.

IMPORTANT

Please identify situations/events of when you want to be notified: _____

_____

_____

_____

Special needs/limitations:

A. Diet:_____
B. Activity:(Attach Physician's Order:) _____
C. Attached Physician Restrictions: _____
D. D. Other considerations: _____

Parents Signature:_____Date:_____

Return this form to the school clinic as soon as possible. Thank you!

Grace Education Academy
HEALTH CARE ACTION PLAN

Student Name _____ Date _____ _ (Copy to be readily available in classroom and clinic)

EMERGENCY PLAN

IN AN EMERGENCY:

1 . Stay with child

2. Call/ask someone to Ms. Kim or Dr. Rivera-Tubbs who will assess the child and summon EMS for this child/or teacher may call EMS.

If you see this:	**Do This:**

Based on the child's current condition a **medical emergency** for this child is

Mother's Name: _____ Work (_} _____ Home (_) _____ _ Cell (_} _____ _

Father's Name: _____ Work(_} _____ Home (_} _____ _ Cell (_) _____ _

Emergency Contact Name: _____ Phone Number: _____ _

Preferred Hospital: _____ _

Primary Physician: _____ _

Specialist(s): ----------