Boston Public Schools Individual Collaborative Health Plan

For Students with Special Health Care Needs

To be completed by Family and Primary Care Provider Year______

Student name:

School

Grade

Student #

DOB

PCP

Student Medical/health issue
(briefly describe/list; may attach any relevant information)

Does the student's impairment interfere with one or more major health activities?

Yes *No*

The purpose of this form is to provide ***preliminary*** *information to the school about an individual student's medical needs. It is a prerequisite for any accommodations.*

If a student has a mental or physical impairment that substantially limits one or more major life activity, he/she may have need of accommodations.

For ongoing communication to occur, both the parent(s)/guardian(s) and the primary care provider (PCP) must sign the release of medical/educational information authorization on the back of the form, as per the federal regulations concerning sharing of educational and health information.

The school nurse may need to share information with support team, food services, the classroom teacher or other staff depending on the student's needs. The family should work with the nurse to determine what needs to be shared with whom. Additional forms and PCP orders may be required, depending on the student's needs. The school nurse will facilitate this and will explain how the information is kept private.

Medications

- ❑ Medication in School

(***State regulations require parent/guardian and physician authorization of nurse administration of school medications)***

- ❑ Other Medications given at home:

Procedures: *(i.e. tube feeding, catheterization, glucose monitoring)*

Activity

Restrictions: (check all that apply)

- ❑ **No restrictions**
- ❑ No contact sports
- ❑ No exertion other than walking
- ❑ No exposure to cold air (such as at recess, bus stop, physical education)
- ❑ No stairs
- ❑ Other

Allergies

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Medical Transportation

- ❑ Door to door (child has no exercise tolerance) duration: _______________
- ❑ Corner to corner (limited exercise tolerance) duration: _______________
- ❑ Special vehicle (wheelchair)

Medical transportation is provided for medical reasons only. Children with illnesses that are in control, i.e. ASTHMA, do not qualify for medical transportation. Safety issues (i.e., bullies, bus stop location, walking distance, parental/guardian illness) require other solutions. Please discuss this with the school nurse.

Dietary

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a licensed physician. **Schools are not required to modify or substitute if there is not a disability.**
- BPS will try to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- BPS may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations.

Check all that apply:

- ❑ Has a **life threatening** allergy to :
- ❑ Has a disabling intolerance to:
- ❑ Has a NON disabling intolerance to:
- ❑ Request for food substitution, NON disabling, reason:

Other Adaptations:

- ❑ **Tutoring Plan:** *(anticipated total absence of > 2 weeks/yr. for chronic illnesses such as Sickle cell, cystic fibrosis, etc.; PCP must complete DOE form:* http://www.doe.mass.edu/sped/28mr/28r3.pdf
- ❑ **Access accommodations: (**i.e., bathroom, elevator, etc.; attach additional information, as needed)

Parent Authorization:

I authorize my child's school nurse to discuss my child's health management with my child's primary care provider, as needed through the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. I understand that information may be privately shared with the school team. I understand that the nurse may dispense medication as ordered by the prescribing physician.

Name: (print)

Signature: Date:

PCP Authorization

I attest that the information provided is accurate and that I have reviewed the plan with the parent/guardian/student.

Name:

Signature:

Date: