## Muscogee County School District Student Health Services 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 Co	ntacts			
	dian/Contact	Relationship	Phone Number	Alternate Phone Number
Healthcare Provid	ler:		Phone Number:	
			<u> </u>	
Medical Diagno	osis / Chronic Cc	ondition (Please de	scribe)	
		•		
Daily Medicatio	ons (List ALL dai	ily and emergency	medications):	
Given at	Medicat	tion Name	Dosage(amount)/Time	When to use
school				19.40.00.00.00.00.00.00.00.00.00.00.00.00.
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## Muscogee County School District Student Health Services STUDENT HEALTH CARE PLAN

	es, sports, field trips, etc):
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	-
Physician's Authorization	
My signature provides for the above orders. I understand that all procedures management regulations. This authorization is valid for one year.	nust be implemented within state laws and
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:
rilysician s raine.	Filone Number.
Division in Company	<b>P</b> . 4
Physician's Signature:	Date:
Physician's Signature:	Date:
Physician's Signature:  Parent Consent for Management of Health Cor	
Parent Consent for Management of Health Cor	ndition at School  te named Healthcare Provider who has mool Clinic Staff any medical information formation to be shared with pertinent the Health Insurance Portable and . However, I expressly authorize in attendance in the Muscogee County
Parent Consent for Management of Health Cor  [Parent/Guardian) hereby authorize the attended to my child, to furnish to the School Health Services Nurse and/or School or copies of records pertaining to my child's health condition and for this in school staff at my child's school. I understand that as of April 14, 2003, under the Accountability Act ("HIPAA") disclosure of certain medical information is limited disclosure of information so that my child's medical needs may be served while	ndition at School  te named Healthcare Provider who has nool Clinic Staff any medical information formation to be shared with pertinent the Health Insurance Portable and  . However, I expressly authorize in attendance in the Muscogee County  ent orders as prescribed above. I agree to
Parent Consent for Management of Health Cor  [	ndition at School  the named Healthcare Provider who has a mool Clinic Staff any medical information formation to be shared with pertinent the Health Insurance Portable and and the However, I expressly authorize in attendance in the Muscogee County ent orders as prescribed above. I agree to there is a change in the student's health