MEDICAL ACCOMMODATIONS REQUEST FORM

Office of School Health | School Year 2020-2021

This form should be submitted along with all relevant forms to this request. Please attach additional documentation, if needed.

Student Name:	OSIS #: _ _ _ _ _ _ _ _ _ _	Student's Date of Birth: ____/____/_______
☐ 504 Request ☐ IEP Request:	IEP Classification: _________________________	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

MEDICAL INTERVENTION

Medical Diagnosis ______________________/ICD-10 Code/DSM-V Code(s): ____.____ ____.____ ____.____

If the request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please complete the Medical Accommodations Request Form Addendum.

This condition is: ☐ Acute ☐ Chronic Expected duration of accommodation: ______ weeks

Request for: ☐ nursing services ☐ paraprofessional support ☐ transportation ☐ other (see Other Services)

Requests for 1:1 nursing, paraprofessional support, and transportation will be reviewed on a case-by-case basis. When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse. Trained paraprofessionals may administer epinephrine and glucagon; all other medications, including insulin, must be administered by a nurse.

Student's current clinical status *(level of control, current management plan, pending evaluations, etc.)*:

Type of Medical Intervention:	Intervention Needed
☐ Administration of Emergency Medications *(e.g. glucagon, rectal diazepam) Please attach all relevant Medication Administration Forms (MAFs).* Please list all emergency medications	☐ during school ☐ during transport
☐ Procedures *(e.g., suctioning, airway management, vagal nerve stimulator) Please complete the Request for Provision of Medically Prescribed Treatment Form* Please list all procedures:	☐ during school ☐ during transport
☐ Equipment Management *(e.g. ventilator, oxygen) Please complete the Request for Provision of Medically Prescribed Treatment Form* Please list all equipment that will accompany the student during school and/or transport:	☐ during school ☐ during transport
☐ Other Services *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form)* ☐ air conditioning ☐ ambulation assistance ☐ elevator pass ☐ other Please list:	☐ during school ☐ during transport

PROVIDERS PLEASE SIGN PAGE 2 →

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STUDENT CONSIDERATIONS

Supervision Required: ☐ none ☐ during school ☐ during transport ☐both

If yes, please document the reason for additional supervision, and the specific tasks/responsibilities that should be performed to support the student during the school day and/or during transport.

Is the student considered medically unstable? *(at risk for medical decompensation during school or during transport)*

☐No ☐Yes (please describe):

Is the student considered behaviorally unstable? *(poses a danger to himself or to other students)*

☐No ☐Yes (please describe):

Does the student currently utilize the following:	☐ Crutches ☐ Cast ☐ Wheelchair ☐ Other:________________________________

Please list any other clinical concerns relevant to supporting the student during the school day and/or during transport (Attach additional information if needed):

How does this diagnosis affect educational performance?

CONTACT INFORMATION & ATTESTATION

Phone number: Office: _ _ _-_ _ _-_ _ _ _ Cell: _ _ _-_ _ _-_ _ _ _					Email:
Best days to be reached:	☐ Mon: Time:_____to_____	☐ Tues: Time:_____to_____	☐ Wed: Time:_____to_____	☐ Thurs Time:_____to_____	☐ Fri: Time:_____to____

I attest that I have provided clinical services to this student and that the information above is complete and clinically accurate as of the date provided below.

Provider's Name (print):	License #: _______________
Provider's Signature:	Date of completion: _ _ /_ _ /_ _ _ _

MEDICAL ACCOMMODATIONS REQUEST FORM ADDENDUM 2020-2021

To Completed by the Student's Health Care Practitioner

Student Name:	**DOB: / /**	**OSIS#:**

Allergies/Anaphylaxis
(note Available School-Specific Allergy Resources listed below)

List allergen(s): ______________________________
____
____

Source of allergy documentation: ☐ Skin Testing ☐ Blood Test ☐ Parental Report
History of Anaphylaxis? ☐ Yes ☐ No
If yes, specify symptoms: ☐Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐Neurologic
Medications ______________________________
____

Was an **Allergy/Anaphylaxis MAF** completed? ☐ Yes ☐ No
Does the student have a history of developmental or cognitive delay? ☐ Yes ☐ No
If yes, specify diagnosis/diagnoses ______________________________
Does the student have prior experience with self-monitoring? ☐ Yes ☐ No
Can the student:

- ☐ Independently self-monitor and self-manage?
- ☐ Recognize symptoms of an allergic reaction?
- ☐ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
- ☐ Follow safety measures established by a parent/guardian and/or school team?
- ☐ Understand not to trade or share foods with anyone?
- ☐ Understand not to eat any food item that has not come from or been approved by a parent/guardian?
- ☐ Wash hands before and after eating?
- ☐ Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
- ☐ Carry an epinephrine auto-injector?

Provider Signature______________________________

Diabetes

When was the student diagnosed with diabetes? ___/___/___
Are current DMAF orders on file at school for this student? ☐ Yes ☐ No
Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? If yes, please specify: ☐ Yes ☐ No
____
____

Can the student identify symptoms of hypoglycemia? ☐ Yes ☐ No
Can the student notify an adult when they feel that their blood glucose is not normal? ☐ Yes ☐ No
What is the plan to transition the student to independent functioning? ______________________________

Provider Signature:______________________________

Seizure Disorder

Type of Seizure ______________________________
Frequency of Seizures ______________________________
Medication(s), including emergency medications ______________________________
____

Are the seizures well-controlled by the current medication regimen? ☐ Yes ☐ No
Does the student require routine or prn emergency medication in school? ☐ Yes ☐ No
If yes, has an MAF been completed? ☐ Yes ☐ No
Other Associated Symptoms, including medication side effects ______________________________
____

Number of seizure-related ER visits during the past year __________
Number of seizure-related hospitalizations/ICU admissions __________
Frequency of office visits/monitoring __________ ☐weeks ☐ months
Last Office Visit ___/___/___
Activity Restrictions ______________________________

Provider Signature______________________________

DO NOT WRITE BELOW - SCHOOL USE ONLY

Available School-Specific Allergy Resources

- ☐ Allergy Table(s) in the lunchroom: _____ staff members for supervision
- ☐ Allergy Table(s) in the classroom: _____ staff members for supervision
- ☐ General Staff Training for Epinephrine administration: _____ staff members trained
- ☐ Student-Specific Training for Epinephrine administration: _____ staff members trained
- ☐ Allergy Response Plan received from school nurse
- ☐ Other: ______________________________

Name of Principal or Principal's Designee: ______________________________