

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

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STUDENT CONSIDERATIONS

Supervision Required: none during school during transport
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? <i>(at risk for medical decompensation during school or during transport)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please describe):</i>
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Is the student considered behaviorally unstable? <i>(poses a danger to himself or to other students)</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please describe):</i>
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Does the student currently utilize the following:	<input type="checkbox"/> Crutches <input type="checkbox"/> Cast <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other:
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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:	<input type="checkbox"/> Mon: Time:	<input type="checkbox"/> Tues: Time:	<input type="checkbox"/> Wed: Time:	<input type="checkbox"/> Thurs Time:	<input type="checkbox"/> Fri: Time:		

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: / /	Student ID#: _____
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**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?
 If yes, specify diagnosis/diagnoses Yes No
 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: _____