

SPECTRUM ACADEMY

Health Care Plan

AUTOIMMUNE DISEASE

Student Name: _____

Date: _____

Autoimmune Disease - caused by a "malfunction" of the immune system attacking the body itself rather than destroying harmful microorganisms. There are over 80 autoimmune diseases in two categories:

- Systemic (causing damage to many organs)
- Localized (causing damage to a single organ or tissue)

1. Student specific autoimmune condition:

2. Signs and Symptoms of Health Concern:

3. Would your student verbalize he/she is having difficulty at school related to health concern?

4. Do you think your student holds back from participating in activities at school because of health concern and why?

5. Does student need special considerations related to health concern while at school?
 - A. Modified classroom
 - B. Lunch room considerations (parent to notify nutrition services for dietary needs)
 - C. Modified PE class
 - D. Modified outside activities
 - E. Field trips
 - F. Seasonal changes
 - G. Emotional or behavioral
 - H. Other:

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- 6. Does student require medications while at school?
 - A. Medications:
 - B. If your student needs assistance with medication in the school, parent and health care provider must complete Davis School District Authorization of School Personnel to Administer Medication Form. This form must be on file in school office with medication.

- 7. Additional Information:

AUTHORIZATION / INFORMED CONSENT / MEDICAL RELEASE

- 1. I have reviewed and am in agreement with the Health Care Plan and I authorize school officials to provide my child with health care services in accordance with this plan. I understand that my student's health information will need to be shared:
 - A. To benefit the student in terms of health maintenance and academic progress.
 - B. When necessary to accommodate the safety and well-being of student and staff.
 - C. With the discretion of the school nurse to determine what is shared and who should know.

- 2. I understand that consent for sharing of health information will remain in effect as long as my student is enrolled in Spectrum Academy and may be revoked at any time in writing by parent / guardian.

- 3. I understand if clarification of the health information is needed, my signature authorized the school nurse to contact the medical provider and authorized the medical provider to release information.

Parent Signature

Date

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Student Name: _____ **Date:** _____

School Personnel Signature

Date

School Nurse Signature

Date

I, _____ agree with and approve the above care plan.
Healthcare Provider - printed name

Healthcare Provider Signature

Date