Spectrum Academy
Health Care Plan

COLOSTOMY

Student Name: _____ **Date:** _____

Colostomy – Surgical opening of a small part of the intestine brought to the surface of the abdomen. It is performed when there is an obstruction or disease of the intestine.

1. Student specific signs and symptoms:

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

3. Does student need special considerations related to health concern while at school?

   A. [ ] Modified classroom
   B. [ ] Modified PE class
   C. [ ] Modified outside activities
   D. [ ] Field Trips
   E. [ ] Seasonal changes
   F. [ ] Emotional or behavioral
   G. [ ] Other

4. 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 the Spectrum Academy **Authorization of School Personnel to Administer Medication** form. This form must be on file in school office / nursing station with medication.
   C. According to Spectrum Academy Policy a responsible student may carry a one day's dose of medication on their person.

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5. 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 / Guardian Signature Date