Spectrum Academy
Health Care Plan

RHEUMATOID ARTHRITIS

Student Name: _____ **Date:** _____

Rheumatoid Arthritis (RA) is a chronic inflammatory autoimmune disorder that affects all areas of the body. RA causes pain, swelling, stiffness and loss of joint function, primarily in the wrists and fingers. It can also affect other organs of the body such as eyes, skin, lungs and blood vessels.

1. Signs and Symptoms of Health Concern:

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

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

4. Does student need special considerations related to health concern while at school?
   A. [ ] Modified classroom
   B. [ ] Lunch room considerations (parent to notify lunch services)
   C. [ ] Modified PE class
   D. [ ] Modified outside activities
   E. [ ] Field Trips
   F. [ ] Seasonal changes
   G. [ ] Emotional or behavioral
   H. [ ] Other

5. Does student require medications while at school?
   A. Medications:

   B. If you student needs assistance with medication in the school, parent and health care provider must complete 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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6. 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

_____ _____
School Personnel Signature Date

_____ _____
School Nurse Signature Date