Atlanta Public Schools
Comprehensive Health Services
Phone: (404) 802-2674
Fax: (404) 802-1608

Department of Special Education / Student Support Team Compliance / Section 504
Authorization to Release Confidential Information

TO: _____ Date: _____
Doctor's Name

_____
Address

_____
City, State, Zip

_____
Phone Fax

RE: _____ _____ _____
Last Name First Name Middle D.O.B. School Attended

To assist in the educational/health planning and placement of the student named above, you are hereby authorized to release the following reports/information.

_____ Psycho/Educational Evaluations
_____ Section 504 Documentation
_____ Speech and Language Evaluations
_____ Audiological Report
_____ Pre-Referral Intervention Information
_____ Other _____

_____ Instructional Plans
_____ Accommodations Plans
_____ Meeting Minutes
_____ Eligibility Report
_____ Vision Report
_____ Completion of APS Medical Packet

These records should be sent to: _____

_____

- *Parent(s)/guardian(s), by signature below, acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed for the purpose of educational / health planning.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPPA"), disclosure of certain medical information is limited. However, I herein authorize the disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Student

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Dr. _____ **Date:** _____
_____
_____
_____

RE: _____ **(D.O.B. _____/_____/_____)**

Thank you for the care you provide to our student. In preparation for the upcoming school year, the school-based educational team, nursing staff, and the family need your input and instructions to assist in the educational health planning for the student named above. Please take the time to fill out our medical packet, which includes the following forms:

1. **Medical Examination Report and Health Care Management Plan**—This assists in providing a detailed and comprehensive overview of the child's health status and needs. Please include specific recommendations for the team relative to safety and ambulation throughout the school building.
2. ***Administration of Medication/Medical Procedures List** - used to document physician orders for routine and PRN medications, nutritional supplements, and other therapeutic/assistive devices (i.e. protective helmet, walker, etc.) (**Note: Please use a separate form for each physician's order to administer medication and/or perform a procedure**)
3. **Medical Statement & Diet Prescription for Meals at School** - used to document orders for alternate nutritional supplements and dietary restrictions, substitutions, or preparation.
4. **Emergency Plan –** created to guide emergency intervention for the student while in school.

All these documents will remain in effect for one school year. **A new set of documents will be required each August prior to school opening.** In the event that new orders are not received, parents have the right and responsibility to administer medications and/or perform special health procedures during the school day. Feel free to keep a blank copy of the forms so you may update them at your convenience in preparation for the next school year. Thank you for your expeditious assistance in creating the optimum learning environment for your patient/our student.

_____ _____ _____
School Nurse / Referring Party **School / Program Location** **Phone**

***Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must give the nurse an appropriate medical order.**

Revised: 8/22/2024

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MEDICAL EXAMINATION REPORT

_____ _____ _____
Student's Name (Last, First, Middle) Birthdate Sex

_____
Home Address Apt. City State Zip Code

_____
Parent(s)/Guardian(s) Names(s) Phone

_____
School (or previous school, if not yet enrolled in APS) Grade

_____
Printed Name and Signature of Referring Party Date

TO BE COMPLETED BY THE PHYSICIAN (M.D. or D.O.)

Diagnosis/Summary of Medical History

_____
_____
_____
_____

Current Medication (if any)/Notable Side Effects

_____
_____

Check all descriptions that may interfere with this student's school functioning:

_____ Frequent absences
_____ Lack of strength
_____ Lack of vitality
_____ Lack of alertness

Limited ability to:
_____ Move about
_____ Sit
_____ Manipulate materials

Sensory impairment(s) resulting in:

_____ Limited vision
_____ Limited hearing
_____ Limited vision and hearing

Skeletal deformities affecting:
_____ Ambulation
_____ Sit
_____ Body use

Additional information regarding this student's disabling condition

_____
_____

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Medical Exam Report – page 2 Student: _____

Description of special health care or emergency procedures, if applicable:

_____
_____
_____

Surgical History: Type of Surgery Date: Results:

_____
_____
_____

Prognosis/Precautions:

_____
_____
_____
_____

Speech Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Occupational Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A
Physical Therapy evaluation follow-up permissible: _____ yes _____ no _____ N/A

Special instructions regarding physical, occupational, and/or speech therapies:

_____
_____
_____
_____

If applicable, name(s) and address(es) of other physicians or medical agencies providing health care to students:

_____
_____
_____
_____

_____ _____
Physician's Signature Date

_____
Physician's Name (Print or Type)

_____
Name of Clinic/Health Facility, if applicable

_____
Address

Return to: _____
_____
_____

Form # 67075-1/670

Revised: 8/22/2024

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Health Care Management Plan

Student: _____ ID: _____

School: _____ DOB: _____

Teacher: _____ Medicaid: _____

Physician: _____ Preferred Hospital: _____

PLEASE PROVIDE SPECIFIC INSTRUCTIONS ADDRESSING THE FOLLOWING AREAS

Description of Student's Current Medical Condition, including Relevant Medical History:

_____
_____
_____
_____

Transportation: Can the student ride the school bus? *(Circle One)* YES NO
If yes, please describe any special assistance (personnel, equipment) or special training needed:

_____
_____

Nursing Specific Procedures/Treatments (Note – Board Policy allows for certain procedures/ treatments to be delegated to trained unlicensed personnel. Please document if/why procedure/treatment may only be performed by RN/LPN):

_____
_____
_____

Special Diet: Does the student require a special diet? (Circle One) YES NO
If yes, please list specific parameters and/or instructions (Diet Prescription form should also be completed):

_____
_____
_____

Assistance with Activities of Daily Living:
The student requires assistance with: *(Circle all that apply)* Dressing Toileting Feeding None
If assistance is required, please explain:

_____
_____
_____

Therapy: The student requires the following type of therapy: *(Circle all that apply)*
Physical Occupational Speech None

If therapy is required, please give specific orders:

_____
_____
_____

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 Student: _____

Adaptive Physical Education:
Are there physical limitations on activities? *(Circle One)* YES NO
If yes, please explain which activities the student may participate in and what the limitations are:

_____
_____
_____
_____

Teaching:
Do school personnel require special training to care for the student? *(Circle One)* YES NO
If yes, please explain what is needed:

_____
_____
_____
_____

Monitoring:
Does the student's health status need monitoring during the school day? (Circle One) YES NO
If yes, please explain:

_____
_____
_____
_____

Medication: (Administration of Medication form should also be completed)
What monitoring is needed for reactions to medication, altered mood or mental status, etc.?

_____
_____
_____
_____

Other Treatments/Procedures (procedures that may be performed by school staff):

_____
_____
_____

Homebound Services / Modified School Attendance Recommendations:
Is it necessary for the student to be educated in the home? *(Circle One)* YES NO
Is it necessary for the student to attend school on a partial day schedule? *(Circle One)* YES NO
If yes, please explain (**Referral for Homebound Services form should also be completed**; this form can be used to request intermittent services):

_____
_____
_____

Physician's Signature _____ Date _____
If you have any questions, please call the Department of Comprehensive Health Services 404.802.2674.

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PLEASE COMPLETE A FORM FOR EACH MEDICATION / MEDICAL PROCEDURE
Reference: APS Policy JGCD – Medication

ATLANTA PUBLIC SCHOOLS
ADMINISTRATION OF MEDICATION / MEDICAL PROCEDURES

Student's Name _____ **Homeroom** _____

Birthdate _____ **Telephone #** _____ **Emergency #** _____

Address _____

Medication / Medical Procedure _____ **Diagnosis** _____

Starting Date of Medication / Medical Procedure _____

Physician's requirements of dosage/method of administration:

_____

_____

(Please indicate if the student is responsible for self-administration and should carry medication/medical equipment.)

Student is capable and recommended to possess and self-administer this medication / medical procedure:

NO _____ **YES-Supervised** _____ **YES-Unsupervised** _____

Time medication / medical procedure is to be provided daily _____

Precautions, possible side effects, interventions _____

Drug / Food Allergies _____

Termination date for administering the medication / medical procedure _____

Physician's Name _____

Physician's Address _____

Telephone No. _____ **Fax No:** _____

Physician's Signature _____ **Date:** _____

- *Parent(s) / guardian(s) by signature below acknowledges that the school is providing for the administration of medication / medical procedure as a courtesy to the parent(s) / guardian(s) and agrees to hold the school and school system harmless in its so doing.*
- *Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent staff as needed.*
- *I understand that the school system can file for partial reimbursement by accessing funds from the Individuals with Disabilities Education Act (IDEA) for administering this medication or procedure.*
- *I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA"), disclosure of certain medical information is limited. However, I herein authorize disclosure of pertinent medical information for the provision of services for my child while in attendance in the Atlanta Public Schools District. This authorization expires as of the last day of this school year, including the summer/ extended year session.*
- **Our school nurses are governed by the Georgia Nurse Practice Act and APS Policy JGCD – Medication, and they will only administer medication in accordance with written medical orders signed by a licensed physician, dentist, or podiatrist. APS nurses will not modify any dosage of medicine based solely on a request or recommendation by a parent or guardian. A parent or guardian seeking a dosage modification must provide the nurse with an appropriate medical order.*

Parent(s) / Guardian(s) Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

Dist: School Clinic – Student's Personal Folder – Parent(s) / Guardian(s) - Health Services Form # 67071 REV 08/10/2016

Revised: 8/22/2024

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EMERGENCY PLAN FOR STUDENT WITH SPECIAL HEALTH CARE NEEDS

EMERGENCY PLAN / Diagnosis: _____

Student: _____ **Date:** _____

Birthdate: _____ **School:** _____

Preferred Hospital in case of an emergency: _____

*In case of serious illness / injury, the school will render first aid as prescribed by School Board Regulations while contacting the parent. If neither the parent nor the designee can be reached and the situation is very serious, the school shall telephone the County Medical Emergency Unit (9-1-1) for immediate transportation to the nearest emergency treatment hospital. Whenever possible, the parent's hospital preference will be observed.

Parent Contact Info: Name _____ **Best Phone #** _____
Healthcare Provider(s): _____ **Phone:** _____
_____ **Phone:** _____

What is this disease/condition/disorder?

_____

_____

If You See This	Do This

IF AN EMERGENCY OCCURS:	**WHEN CALLING 9-1-1:**
1. If the emergency is life-threatening, immediately call 9-1-1. 2. Stay with student or designate another adult to do so. 3. Call or designate someone to call the School Nurse and/or Principal.	1. State who you are. 2. State where you are (street address and exact location in the building). 3. State problem (Note: have copy of clinic card record available to send to ER).

TRAINED EMERGENCY RESPONDERS:

_____ _____
Signature of Physician or Authorized Medical Authority **Date**

_____ _____
APS RN Review/Approval: **Date**

Revised: 8/22/2024

Atlanta Public Schools School Nutrition Department

Special Diet Request Form

All fields must be completed. The APS School Nutrition Department shall not accept incomplete forms. Write "n/a" if field not applicable.

PART A: Parent/Legal Guardian	
Student's Name (Please Print):	Student ID:
DOB (mm/dd/yyyy):	School:
Grade Level:	Teacher's Name:
Parent/Guardian Name(s) (Please Print):	
Parent/Guardian Phone Number:	Parent/Guardian Email:

Which meal(s) will the student eat from the cafeteria?

☐ Breakfast ☐ Lunch ☐ Usually brings from home

Does your child/student require lactose-free milk? ☐ Yes ☐ No

Please describe your child/student's nutritional request for lactose-free milk:

My child/student requires lactose-free milk due to:_____

***Please note**: A request for lactose-free milk does not require a medical provider's signature. However, a **request for an alternative milk (almond milk, soy milk, etc.) DOES require a medical provider's signature.** If requesting an alternative milk, please have child/student's medical provider complete the rest of this form.*

I give APS Nutrition Department permission to speak with my child/student's medical provider to discuss dietary needs described below. I have read the APS Nutrition Department Special Diet Request information found on the back of this page.

Parent/Guardian Signature:	Date:

PART B: Disability* or Food Allergy/Intolerance

To be completed by a LICENSED MEDICAL PROVIDER

**Under Section 504 of the Rehabilitation Act 1973 and the American with Disabilities Act 1990, a person with a "disability is any person who has a physical or mental impairment that substantially limits one or more life activities", including food allergies or intolerances.*

Explain how the disability restricts the student's diet:

Major life activity(s) affected (check all that apply)

- ☐ Caring for self
- ☐ Walking
- ☐ Eating
- ☐ Speaking
- ☐ Seeing
- ☐ Other:
- ☐ Manual Tasks
- ☐ Hearing
- ☐ Learning & Working
- ☐ Breathing

Food(s) to be omitted (check all that apply)

- ☐ Peanuts
- ☐ Tree Nuts
- ☐ Soy
- ☐ Fish
- ☐ Wheat
- ☐ Other:
- ☐ Shellfish
- ☐ Fluid Milk
- ☐ All Dairy
- ☐ Egg

Please list foods that may be substituted:_____

_____

Can the child consume foods when the allergen(s) is listed as an ingredient in the food product? (Example: Whole eggs and scrambled eggs are omitted but egg as an ingredient in pancakes & waffles is allowed.) Yes No

Explain (be specific):_____

List any texture modifications that need to be made (chopped, pureed, etc.):	Therapeutic Diet Order-LIST SPECIFIC PRESCRIPTION:
Medical Authority Name (printed):	Date:
Medical Authority Signature:	Credentials (i.e. MA, NP, PA):
Clinic/Facility Name:	Phone Number:

Please Return to: APS School Nutrition Department Registered Dietitian:

linda.ankner@apsk12.org

Please note that cafeteria managers are unable to process any documents. See back page of this document for additional information.

DOCUMENTATION

To obtain special diet accommodations for a student, the APS School Nutrition Department Special Diet Request form shall be completed and signed by a licensed, recognized medical authority.
Per the United States Department of Agriculture the following information is **required** in order to provide accommodations:
Children with Disabilities

- Identification of the student as having a disability (physical or mental impairment)
- Explanation of how the disability restricts the child's diet
- The major life activities affected by the disability
- Foods to be omitted
- Food or choice of foods that must be substituted

The APS School Nutrition Department shall not accept incomplete forms; please note if documentation received is incomplete or requires further clarification, dietary accommodations shall not begin until all information is provided.

Notes written by parents or Special Diet forms without a physician or medical authority's signature are not approved documentation and shall not be accepted. Except when requesting lactose-free milk.

Changes to existing dietary accommodations and the alert on a student's account shall not be removed or changed without documentation in writing from parent/guardian or medical authority. If any accommodation currently in place needs to be removed, the School Nutrition department requires a written request to be submitted to the Registered Dietitian.

A new Special Diet form **does not** need to be submitted each school unless there are changes to the student's current Special Diet Form.

TIME FRAME

Dietary accommodations may take up to 1 week to process, especially at the beginning of the school year. Families will be contacted by APS Registered Dietitian within 24 hours of the Registered Dietitian receiving the completed form.

ALLERGEN INFORMATION

Specific food substitutions shall only be made for students with a disability and/or food allergy as listed by the medical authority.
APS School Nutrition Department does not monitor allergens for any a la carte purchases made by students.
Although the APS School Nutrition Department attempts to be completely nut-free, some products may carry an advisory statement such as "processed in facility" or "may contains…". Therefore, the department is Nut-Cautious and please refer to the allergens listed online in MealViewer.
APS School Nutrition Department makes every attempt to identify ingredients that may cause reactions in people with food allergies. Allergen information posted is based on information that the School Nutrition Department currently has on file. Allergen information is subject to change based on manufacturers and APS is not always notified of these changes