

MEDICAL ACCOMMODATIONS REQUEST FORM
Office of School Health | School Year 2021-2022

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 nursing or paraprofessional support, will be reviewed on a case-by-case basis to determine whether the student needs 1:1 support or school-based support. 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. Requests for transportation accommodations will be reviewed on a case-by-case basis. Prior to commencement of services, Medication Administration Forms (MAFs) must be submitted for all medications, procedures, supervision, and monitoring performed during school hours.

Student's current clinical status (*level of control, current management plan, pending evaluations, etc.*):

Type of Medical Intervention:	Intervention Needed
<input type="checkbox"/> Administration of Medications Please complete and submit all applicable Medication Administration Forms (MAFs: Allergy & Anaphylaxis, Asthma, Diabetes, General, Seizure). <input type="checkbox"/> Emergency Medications (e.g. glucagon, rectal diazepam) Please list all emergency medications, including time frame for administration Will student require daily administration of medication during school hours? <input type="checkbox"/> Yes <input type="checkbox"/> No Will student require in-school medications 3 or more times per day? <input type="checkbox"/> Yes <input type="checkbox"/> No List daily medications here, or attach MAFs.	<input type="checkbox"/> during school <input type="checkbox"/> during transport
<input type="checkbox"/> Procedures and Treatments, Routine and Emergency (<i>e.g., suctioning, airway management, vagal nerve stimulator</i>) Please complete and submit the Request for Provision of Medically Prescribed Treatment Form (Non-Medication) Please list, including timing and frequency of administration during the school day.	<input type="checkbox"/> during school <input type="checkbox"/> during transport
<input type="checkbox"/> Equipment Management (<i>e.g., ventilator, oxygen</i>) Please complete the Request for Provision of Medically Prescribed Treatment Form (Non-Medication) Please list all equipment that will accompany the student during school and/or transport:	<input type="checkbox"/> during school <input type="checkbox"/> during transport
<input type="checkbox"/> Other Services Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form, if applicable) <input type="checkbox"/> air conditioning <input type="checkbox"/> ambulation assistance <input type="checkbox"/> elevator pass <input type="checkbox"/> other Please list:	<input type="checkbox"/> during school <input type="checkbox"/> during transport

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STUDENT CONSIDERATIONS

Supervision/Monitoring Required: none during school during transport

Supervision/Monitoring Frequency: continuous other

Please describe the additional supervision/monitoring needed, including the tasks/responsibilities:

Is the student considered to be medically unstable (At risk for medical decompensation during school or transport)?

Yes (please describe below) No

Is the student considered to be behaviorally unstable (poses a danger to themselves or to other students)?

Yes (please describe below) No

Does the student currently utilize the following: Crutches Cast Wheelchair Other: _____

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? Does the diagnosis have an impact on learning, participation, or attendance in school? If so, please describe.

CONTACT INFORMATION & ATTESTATION

Phone number - Office: _____ Cell: _____ Email: _____

Best days to be reached:

Mon-Time: _____ Tue-Time: _____ Wed-Time: _____ Thu-Time: _____ 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#: _____

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 system(s) affected: Respiratory Skin GI Cardiovascular Neurologic Medications
Medications: _____

Was an **Allergy/Anaphylaxis** MAF completed? Yes No
Does the student have a history of developmental or cognitive delay? Yes No
If yes, specify diagnosis/diagnoses: _____
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? _____
Was a **Diabetes** MAF completed 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? Yes
If yes, please specify: _____
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: _____
Was a **Seizure** MAF Completed? Yes No
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 signs and 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: _____