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
☐ Administration of Medications *Please complete and submit all applicable Medication Administration Forms (MAFs: Allergy & Anaphylaxis, Asthma, Diabetes, General, Seizure).* ☐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 □ Yes □ No Will student require in-school medications 3 or more times per day? □ Yes □ No *List daily medications here, or attach MAFs.*	☐ during school ☐ during transport
☐ Procedures and Treatments, Routine and Emergency *(e.g., suctioning, airway management, vagal nerve stimulator) 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.	☐ during school ☐ during transport
☐ Equipment Management *(e.g. ventilator, oxygen) 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:	☐ during school ☐ during transport
☐ Other Services *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form, if applicable)* ☐ air conditioning ☐ ambulation assistance ☐ elevator pass ☐ other Please list:	☐ during school ☐ during transport

PROVIDERS PLEASE SIGN PAGE 2 →

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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 themself 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:_____	☐ Tues: Time:_____	☐ Wed: Time:_____	☐ Thurs 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 2021-2022

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 _____

_____

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? If yes, please specify: □ Yes □ No

_____

_____

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: _____