

MEDICAL ACCOMMODATIONS REQUEST FORM

Office of School Health | School Year 2022-2023

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="radio"/> Yes <input type="radio"/> No Will student require in-school medications 3 or more times per day? <input type="radio"/> Yes <input type="radio"/> 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

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 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 2022-2023

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: _____