Phoenix Union High School District

SPECIAL DIET HEALTH CARE ACTION PLAN AND PHYSICIAN ORDERS
PLAN DE ACCIÓN ESPECIAL PARA LA ATENCIÓN MÉDICA DE LA DIETA Y PEDIDOS MÉDICOS

School Year (Año Escolar): _____ Grade (Grado): _____ Date of Birth (Fecha de Nacimiento): _____

Student Name (Nombre de Alumno): _____ Student ID #: _____

Parent/Guardian Name (Nombre de Padre/Madre/Tutor): _____

Cell Phone (Teléfono Cellular): _____ Work (Trabajo): _____ Home (Casa): _____

Physician (Nombre del Medico): _____ Phone (Teléfono): _____

The parent/guardian agree and understand that they are responsible for maintenance of equipment, furnishing all equipment, medications, and supplies necessary in providing services to the student during school hours. The parent/guardian is also responsible for notifying the school nurse anytime there is a change in orders, medications, and/or in the student's medical condition.

I give permission for the school to allow authorized trained school personnel to administer medications and perform medical procedures as ordered by the physician/healthcare provider licensed in Arizona. I authorize the school to contact my child's physician/healthcare providers and/or dispensing pharmacies, should any questions, any additional orders and/or necessary documents be required for the care of my child during school hours.

El padre / tutor acuerda y entiende que es responsable del mantenimiento del equipo, el suministro de todo el equipo, los medicamentos y los suministros necesarios para proporcionar servicios al alumno durante el horario escolar. El padre / tutor también es responsable de notificar a la enfermera de la escuela cada vez que haya un cambio en las órdenes, medicamentos y / o en la condición médica del estudiante.

Doy permiso para que la escuela permita que el personal autorizado de la escuela capacitada administre medicamentos y realice procedimientos médicos según lo ordenado por el médico o proveedor de servicios de salud con licencia en Arizona. Autorizo a la escuela a ponerse en contacto con el médico de mi hijo / proveedores de atención médica y / o farmacias de entrega, en caso de tener preguntas, pedidos adicionales y / o documentos necesarios para el cuidado de mi hijo durante el horario escolar.

_____ _____

Parent/Guardian Signature (Firma de Padre/Madre/Tutor) Date (Fecha)

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FOR LICENSED PHYSICIAN/HEALTHCARE PROVIDER USE ONLY - PLEASE WRITE LEGIBLY

THE PHOENIX UNION HIGH SCHOOL DISTRICT IS REQUESTING YOUR ASSISTANCE IN COMPLETING THIS THREE-PAGE FORM TO IDENTIFY ANY SERVICES THAT WE MAY NEED TO PROVIDE TO THE STUDENT IN THE SCHOOL SETTING.

Physician's Statement for Children with Disabilities require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. Medical Statement for Children with Special Dietary Needs must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority.

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Student Name: _____ School Year: _____

Under no circumstances are school food service or school personnel to revise or change a diet prescription or medical order

STUDENT MEDICAL DIAGNOSIS: _____

_____

Describe the student's condition and the major life activity affected by the condition related to the need for dietary modification:

_____

_____

Medication and/or Food Allergies and Type of Reaction: ☐ None

_____

Seating student when eating/drinking/being fed: ☐ Regular seating ☐ Wheelchair ☐ At table ☐ Tray attached ☐
Special seating required (describe):

_____

Positioning the student when eating/drinking/being fed:

☐ Independently upright ☐ Fed self completely ☐ Partially assisted ☐ Fed entirely by other(s)

☐ Supported upright and how/other positions?

_____

DIETARY MODICATIONS AND PHYSICIAN ORDERS ☐ **SEE MEDICAL DOCUMENTS/ORDERS ATTACHED**

Indicate which dietary modifications the student needs and specify what changes need to be made. *(Substitutions or modifications for children with disabilities must be based on a prescription order written by a licensed physician/healthcare provider)*.

List the food or foods to be omitted from the student's diet?

_____

_____

_____

TEXTURE MODICATION: ☐ Pureed ☐ Ground ☐ Chopped ☐ Other: _____

Specify Foods: _____

Volume or quantity of food/liquid per presentation: _____

Number of swallows per bolus: _____

Provide _____ (quantity, type) liquid after _____ (number) of food presentations.

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PLAN DE ACCIÓN ESPECIAL PARA LA ATENCIÓN MÉDICA DE LA DIETA Y PEDIDIOS MÉDICOS

Student Name: _____ School Year: _____

NUTRIENT MODICATION: ☐ Increase Calories Description: _____

Supplement Name: _____

☐ Decrease Calories Description: _____

☐ Nutrient Restriction Description: _____

FEEDING SCHEDULE DURING SCHOOL HOURS: ☐ Breakfast ☐ Lunch ☐ Other: _____

FOOD PRESENTATION: ☐ Bottle ☐ Cup ☐ Straw ☐ Spoon ☐ Fork ☐ Bowl ☐ Plate

SPECIAL MEALTIME EQUIPMENT: ☐ None ☐ Built-Up Handle ☐ Angled Handle ☐ Scoop Bow

☐ Other: _____

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PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE REQUIRED BY THE SCHOOL

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Physician/ Healthcare Provider Signature: _____ Date: _____

Physician/Healthcare Provider Printed Name: _____

Telephone: _____ FAX Number: _____

Please attach any additional documents provided by the parent/guardian and physician/healthcare provider

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School Use Only

School Name: _____

School Designated Personnel: _____ Phone: _____

Reviewed by School Personnel Signature: _____ Date: _____

Revised October 4, 2017, 2/26/18, 3/8/18, 4/12/18, 5/10/18, 8/12/18, 5/4/20
Student Health Services and Exceptional Student Services