



**MORAGA SCHOOL DISTRICT**  
1540 SCHOOL STREET • MORAGA, CA 94556  
(925) 376-5943

## MEDICAL HISTORY & CONSENT FORM

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Known Allergies/Health Conditions: \_\_\_\_\_

You have provided information that indicates your child has allergies or other health conditions. In order to attend to your child's health and safety, the school requires a diagnosis from a physician indicating severe allergies or other health conditions. Please attach this form to the diagnosis and return them to the school office. This will become part of your child's confidential school health record. With your written consent, below, this information will be shared with school personnel. Please keep the school informed of any changes in your child's condition or medication schedule. Our primary concern is that your child's health care needs are met while s/he is attending school.

### **Management of Illness at School and School Sponsored Events**

1. The purpose of an Individualized School Health Care Plan (ISHCP) is to provide safe management of health care and services for students at school and during school-related activities.
2. The ISHCP is developed by school personnel in collaboration with the student's parent/guardian, authorized health care provider and student, if appropriate.
3. The ISHCP is a management tool that follows the health care process and includes:
  - a. Procedures for health care provisions of the student in school and a school schedule plan of who will do what, when, where and how.
  - b. Designated training provided as necessary.
  - c. Parent written consent for the ISHCP.
4. The ISHCP may be included in, and attached to, a 504 Plan and/or an IEP, when appropriate.
5. All authorized health care provider changes must have written health care provider authorization and written parent consent provided to the school office. Revisions, not requiring authorized health care provider authorization, may be made with written parent consent.
6. ISHCP review must occur annually and/or whenever changes are necessary to ensure provision of safe care.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_