Chronic Condition Protocol

Date:_____

Dear Parent/Guardian of:_____

You have indicated that your student has a chronic diagnosis of:

_____.

Please complete this form and return to the School Nurse for a plan to help your child can be shared with appropriate school personnel. Please be assured that staff will keep this information confidential.

Your student's symptoms of this diagnosis:_____

_____

Has hospitalization been needed in the past year for this health condition?☐No ☐Yes

Date of last hospitalization :_____

Medical Provider:_____

Medications for this diagnosis:_____

Treatment plan:_____

_____

_____

Nursing care needed at school? ☐No ☐Yes Describe:_____

_____

_____

Parent Signature:_____Date:_____