

CUMBERLAND COUNTY SCHOOLS

Physician's Health Care Orders for Osteogenesis Imperfecta

Student First Name: _____ Last Name: _____ D.O.B. ____/____/____
 School Name: _____ Grade: _____ School Year: _____
 Preferred Hospital Name: _____ Street Address: _____
 City/State/Zip Code: _____/_____/_____ Phone: (____) _____

Care Needs and Support Plan for School *(to be completed by the student's medical provider)*

Osteogenesis Imperfecta Type Diagnosed: _____ Date of Diagnosis: ____/____/____
 List additional diagnoses/conditions if any: _____

Mobility and Physical Activity		Fracture Risk and Emergency Protocol	
☐ Uses wheelchair ☐ Uses walker/crutches/cane ☐ Walks independently ☐ Requires adult assistance during transitions	Stair Use: ☐ Allowed ☐ Not allowed ☐ Elevator required	Signs of Possible Fracture <i>(Please check all that apply):</i> ☐ Sudden pain ☐ Swelling ☐ Bruising ☐ Deformity ☐ Crying ☐ Immobility	Action Steps in Case of Injury or Emergency: 1. Do not move the injured limb or student. 2. Notify parent/guardian 3. Call 911 if the injury is severe or life-threatening.
Lifting/carrying instructions (if needed): _____ _____			
Playground/physical activity modifications: _____ _____		Other indications of possible fracture: _____ _____	
Medication		Toileting and Personal Care	
☐ No medication administered at school ☐ Yes, medication to be administered at school: _____ If yes, please complete the CCS Physician's Medication Form.		☐ Independent ☐ Requires assistance (details): _____ _____ ☐ Needs adaptive equipment: _____ _____	
Accommodations in Class		Transportation Needs	
☐ Preferential seating ☐ Use of assistive devices ☐ Other: _____		☐ Requires wheelchair-accessible transportation ☐ Requires adult assistance during transportation ☐ Other: _____	

Physician's notes: _____

Physician's Name (Please Print): _____
 Physician's Signature: _____
 Office Name: _____
 Address: _____
 Phone: (____) _____ Fax: (____) _____

MD Stamp

Date: ____/____/____

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Physician's Health Care Orders for Osteogenesis Imperfecta Continued

Parent/Guardian Information *(to be completed by the student's parent or guardian)*

Parent/Guardian Name: _____	Phone: (____) _____	Phone: (____) _____
Parent/Guardian Name: _____	Phone: (____) _____	Phone: (____) _____
Emergency Contact Name: _____	Phone: (____) _____	Phone: (____) _____
Emergency Contact Name: _____	Phone: (____) _____	Phone: (____) _____

Release of Liability

I, _____ (Parent/Guardian Name), the parent and/or legal guardian of _____ (Student Name), enrolled at _____ (School Name), understanding the importance of administering medication as prescribed by my child's physician, hereby agree to release and hold harmless designated school personnel from any liability related to the administration of medication, including injections, to my child. I acknowledge that I have discussed this matter with my physician and/or legal counsel, and fully understand the potential ramifications of this consent. I grant permission for the medical provider to disclose necessary health or medical information regarding the prescribed medication to the school personnel involved in its administration. I understand that I have the right to revoke this consent at any time, except where actions have already been taken based on this consent. This consent remains valid for one year or until I revoke it in writing, whichever occurs first.

Parent or Legal Guardian Signature: _____	Date: ____/____/____
Principal Signature: _____	Date: ____/____/____