Anchorage School District

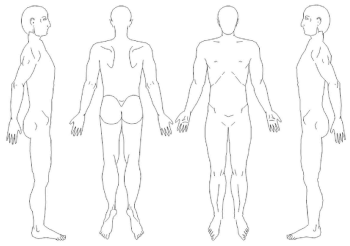
Musculoskeletal Injury Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

Student Photo

MEDICAL PROVIDER AUTHORIZATION

BACKGROUND OF INJURY AND DIAGNOSIS



ASSISTIVE DEVICES

☐ None ☐ Boot ☐ Brace ☐ Cane ☐ Crutches ☐ Scooter ☐ Splints ☐ Wheelchair

☐ Other: _____

ACTIVITY RESTRICTIONS *(please consider student activities, e.g., monkey bars, swings, weights, climbing, etc.)*

☐ No restrictions ☐ No physical activity ☐ Modified PE/recess/sports (walking, stretching only)

☐ Other restrictions *(describe)* _____

MEDICATION ORDER

Med: _____ Dose: _____ Route: _____ Frequency: _____ Indication: _____

Med: _____ Dose: _____ Route: _____ Frequency: _____ Indication: _____

OTHER INFORMATION

DURATION AND FOLLOW-UP

These orders are expected to last through _____. A follow-up has been scheduled for _____.

MEDICAL PROVIDER NAME/TITLE	***PHONE NUMBER***	***EMAIL***
MEDICAL PROVIDER SIGNATURE		***DATE***

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the nursing care outlined in this plan be provided to my child. I will provide the necessary supplies and/or medications for care in school.

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining care supplies and/or medications will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	***RELATIONSHIP TO STUDENT***	***PHONE NUMBER***
PARENT/GUARDIAN SIGNATURE		***DATE***

NURSE PLAN REVIEW

I have reviewed this nursing care plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and wellbeing of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	***DATE***