Carroll ISD Health Services
Parental Authorization for GI Action Plan

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name:_____ **D.O.B.:**_____ **Grade/Teacher:** _____

Parent/Guardian: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Transportation: ◯ Car rider ◯ Walker ◯ Drives Self ◯ Rides Bus # _____
Diagnosis/Significant Medical History:_____
_____
Allergies:_____
Procedures, Devices, Treatments: (Please check all that apply)
____Ostomy ____ Enteral Feeding ___ Central Venous Access device _____Diet/ Dietary Restrictions
If any apply, please state details: _____
_____
_____
Non-pharmacologic treatments: _____
_____
Triggers/ Precipitating Factors or Restrictions: _____
_____
Is student able to?

- Identify and avoid food intolerances ◯yes ◯no
- Select appropriate treatments based on severity of symptoms ◯yes ◯no
- Perform bowel management program ◯never ◯ sometimes ◯often ◯consistently ◯n/a
- Free of bowel incontinence ◯never ◯ sometimes ◯often demonstrated ◯consistently demonstrated

Medication at school: _____
_____
Nutrition and Fluid Management Needs: _____
_____
_____
Medical Device Needs- _____
_____
_____
Elimination/ Toileting Needs: _____
_____
_____
Physical Activity Needs/ Restrictions: _____
_____
_____
Additional Instructions: _____
_____

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.

Physician- Print Name:	Physician Phone:
Parent/ Guardian Signature:	Parent/ Guardian Phone: