Medically Fragile Case Management Program
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Medically Fragile Case Management Program Worksheet

Team Members		Date:
Name	Relationship	Contact Number

Student Information		
Student name: (Last, middle initial, first)		DOB:
Lives with:	Relationship:	
Communication/language preference:		
Contact numbers:		E-mail address:
Previous school (include pre-school and early intervention program)		Current grade:
Primary Care Provider (PCP):	Phone:	
Specialty Care Provider (SCP):	Phone:	
Date of last PCP visit:	Date of last SCP visit:	
Case Manager:	Phone:	
Briefly describe student's current health status.		

No	Yes	Airway and Breathing		Follow-up/Notes
☐	☐	Does student have any difficulty breathing?		
☐	☐	Does student use an inhaler?	How frequently?	
☐	☐	Does student use oxygen?	How is it administered?	
☐	☐	Does student use an apnea monitor or oxygen saturation machine?		
☐	☐	Does student have a tracheostomy?		

Medically Fragile Case Management Program Worksheet

☐	☐	Does student require suctioning?			
		☐ Nasal	☐ Oral	☐ Tracheal	
		How frequently?			
Comments:					

No	Yes	**Allergies**			**Follow-up/Notes**
☐	☐	Does your child have any allergies (food, medication, environmental?			
☐	☐	Does student require administration of emergency medication for allergies?			
		Allergy	Typical Reaction	Typical Treatment	

No	Yes	**Seizure Disorder**	**Follow-up/Notes**
☐	☐	Does student have a history of seizure activity?	
		Date of last seizure:	
		Describe 'usual' seizure activity, frequency and triggers.	
☐	☐	Does student take medication to control seizure activity?	
☐	☐	Daily medication: List	
☐	☐	Emergency medication: List	
☐	☐	Does student require special treatment after a seizure? Please describe:	

No	Yes	**Hearing and Vision**		**Follow-up/Notes**
☐	☐	Does student have any difficulty with vision?		
☐	☐	Does student wear glasses or contacts?		
		Name of eye doctor:	Date of last eye exam:	
☐	☐	Does student have other concerns with vision? Explain:		
☐	☐	Does student have difficulty with hearing?		
☐	☐	Does student wear hearing aids?		
☐	☐	Does student utilize adaptive equipment to assist hearing? List		
		Date of last hearing test:	Performed by?	
☐	☐	Does student have any other concerns with hearing? Explain:		

Medically Fragile Case Management Program Worksheet

Communication Strategies			Follow-up/Notes
What strategies does student use to communicate?			
☐ Verbal	☐ Nonverbal	☐ Verbal with Assist	
☐ Voice output device	☐ Picture Book	☐ Sign	
☐ Other: Please explain:			
Briefly describe how student asks for help.			

Behavior				Follow-up/Notes
Please indicate if your child has any sensory or behavioral concerns.				
☐	Social Skills	☐	Emotional needs	
☐	Behavioral Concerns	☐	Tactile, visual or auditory triggers?	
☐	Other triggers?			
Please Explain:				
Briefly describe positive reinforcement behaviors that are especially effective with your child.				
Does your child normally require a nap during the school day? ☐ No ☐ Yes				
Please describe time and duration of nap.				

Mobility				Follow-up/Notes
☐	Walks independently	☐	Uses wheelchair independently	
☐	Walks with assistance	☐	Uses wheelchair with assistance	
☐	Uses assistive devices for mobility	☐	Requires assistance with transfers	
☐	Special assistance with head control	☐	Wears AFO's	
☐	Requires special care during positioning and or transfers to address spasticity or tone. Explain:			
Height Weight				
Please describe student preferences for positioning during the day.				
How frequently does student require assistance with repositioning or AFO's?				
Briefly describe any other mobility needs:				
How will student be transported to school?	Bus ☐	Private Vehicle ☐		

Medically Fragile Case Management Program Worksheet

Briefly describe any special considerations regarding transport to school:	

No	Yes	Feeding and Nutrition			Follow-up/Notes
☐	☐	Does student eat orally? Please describe special diet preparation including food likes and dislikes.			
☐	☐	Does student require assistance with eating? Explain:			
☐	☐	Does student have a feeding tube?	Size?	Type?	
☐	☐	Does student have a history of aspiration, choking or reflux?			
		Date of last swallow study?			
		Special instructions regarding positioning during eating?			
		Special instructions regarding type and frequency of feeding?			
☐	☐	Does student require special equipment for eating? Explain:			

No	Yes	Diabetes	Follow-up/Notes
☐	☐	Does student require monitoring blood sugar levels?	
		How frequently?	
☐	☐	Does student take medication to control blood sugar levels?	
☐	☐	Daily Medication? List:	
☐	☐	Emergency medication? List:	

Self-Care Skills				Follow-up/Notes
	Independent	Assisted	Total Care	
Dressing	☐	☐	☐	
Toileting	☐	☐	☐	
Briefly describe, include any issues with temperature regulation or tactile issues related to clothing:				

No	Yes	Daily Medication				Follow-up/Notes
☐	☐	Does student require medication during the school day?				
Name		Dose	Route	Time	Reason	

Medically Fragile Case Management Program Worksheet

Recommendations	Completed	NA
☐ Exam by PCP		
☐ Exam by Specialist(s)		
☐ History and physical		
☐ Daily Medication Orders		
☐ Emergency Medication Orders		
☐ Over the Counter Medication Orders		
☐ Authorizations for feeding		
☐ Authorization for special procedures		
☐ Respiratory supplies:		
☐ Medication supplies needed from home		
☐ Feeding supplies needed from home		
☐ Toileting supplies needed from home		
☐ Mobility/Positioning supplies needed from home		

School staff has received training to address the following identified needs:		Follow-up/Notes
☐ Medication Administration	☐ Positioning	
☐ Feeding	☐ Transferring	
☐ Toileting	☐ Emergency Plans	
☐ Daily Care Schedule	☐ Other	

No	Yes	School/Classroom Visit Date:_____	Team Review Date: _____	Follow-up/Notes
☐	☐	Classroom is accessible		
☐	☐	Learning environment within class is accessible		
☐	☐	Bathroom is accessible		
☐	☐	Hot and cold running water in classroom		
☐	☐	Hot and cold running water in bathroom		
☐	☐	Changing table		
☐	☐	Other equipment needed? Describe:		
☐	☐	Transportation Plan Instituted		
☐	☐	IEP Scheduled	Date:	

Additional Notes

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