GENERAL MANAGEMENT PLAN

Student Name _____Birthdate_____Grade/Teacher_____

School Name_____ School Year_____

1. Health Condition:_____
2. When was your child diagnosed with the health condition: _____
3. Date of last medical evaluation: _____
4. Name of physician following health condition: _____
5. Please describe your child's condition and how you would like us to manage it a school:

_____

_____

_____

- Restrictions or precautions:_____
- Self Esteem/Coping:_____
- Therapies or treatments (physical therapy, counseling):_____

_____

- Medications:_____
- Other: _____

_____

If you see this (Describe Symptoms):	**Do this (List actions to take):**

If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

School Nurse Signature_____ Date Reviewed_____