 This information expires on June 30, _____

District or School Name
Address
Phone and Fax Numbers

Student Photo

MEDICAL MANAGEMENT PLAN

Student Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____

Teacher(s): _____

Condition: _____

_____

Symptoms and Consequences:_____

_____

_____

Medical Management Actions:

IF THIS	PERFORM THIS ACTION

Emergency Procedures: _____

_____

_____

_____

Emergency Contacts:

1. **Name:** _____
   Phone: _____ **Relation to student:** _____
2. **Name:** _____
   Phone: _____ **Relation to student:**_____
3. **Name:** _____
   Phone: _____ **Relation to student:** _____

 This information expires on June 30, _____

General Safety Recommendations and Restrictions

In the classroom: _____

_____

_____

In the cafeteria: _____

_____

_____

On the playground and in the gym: _____

_____

_____

On field trips: _____

_____

_____

During transportation: _____

_____

_____

Other: _____

_____

_____

Healthcare Provider Name: _____

Address: _____ **Phone:** _____

Healthcare Provider Signature: _____ **Date:** _____

To be completed by parent/guardian:

I, (parent/guardian), _____ request that my child, _____, receive the above described medical management at school according to standard school policy, and for the ordering healthcare provider staff and school staff to share information as needed to assist my child with his/her identified health care needs.

Parent/Guardian Signature: _____ **Date:** _____