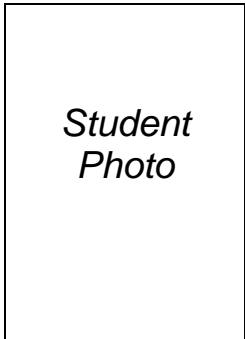


District or School Name

Address

Phone and Fax Numbers

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: _____

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:** _____