General Health Condition Management & Emergency Plan

RN Verified_____

Student_____ Grade_____ Date_____

Date of Birth_____ School_____ Teacher_____

Emergency Contacts

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Section 1: Health Information

Medical diagnosis/health concern: _____

_____

_____

_____

Describe what action(s) should be taken to manage health condition at school:

_____

_____

_____

_____

Describe what action(s) should be taken in an emergency situation (if applicable): _____

_____

_____

_____

Section 2: Medication

Will your child need medication(s) at school for the above health condition?

- ☐ Yes
- ☐ No

Section 1: Prescription Medications

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

**Route = oral, inhaled, topical, injectable, etc.*

All prescription medications must be in a properly labeled pharmacy box/bottle. Ask your pharmacy for additional labeled containers needed for school.

Section 3: Hospital Information

If a parent/guardian or emergency contact cannot be reached, I authorize school staff to call 911 and transport my child to _____ Hospital for medical care.

Parent Consent For Management Of Health Condition While At School Or Other School Related Activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date_____

Provider Information/Consent (Provider only needs to sign if student has medication to be given at school)

Name of Provider_____ Clinic Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

**Note to Health Care Provider-This document serves as medication and treatment orders.*