OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

School: ______________________________ **Date:** _______________

MEDICAL MANAGEMENT PLAN / HEALTHCARE PROVIDER'S REPORT

(To be completed by your child's doctor, nurse practitioner or other healthcare provider)

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

Student's Name: ____ **Birth date:** _______________

Diagnosis: ____

Significant Findings: ____

____

____

Does this condition impact a major life activity? ☐**Yes** ☐**No**

If yes, please state the major activity(ies) impacted: ____

____

Medications and/or treatment ordered: ____

____

The following are possible signs of an impending crisis: _______________________________________

____

Steps to be taken:

1) ____
2) ____
3) ____
4) ____

Signs that indicate the need for immediate medical care: ______________________________________

____

Recommendations for physical activity: ☐**unrestricted** ☐**restricted (explain)** ☐**supervision (explain)**

____

____

Medication: Is the student required to take medication during school hours? ☐**No** ☐**Yes. If so, please fill out the attached medication form. Thank you.**

______________________________	______________________	____________________
Healthcare Provider's Signature	**Telephone**	**Fax**
______________________________	______________________________	_____________
Healthcare Provider's Name/Stamp	**Address/City**	**Date**

If you have additional questions contact HealthServices@ousd.org || www.ousd.org

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