Health Management Care Plan

Student Information:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Parent/Guardian Information:

Parent/Guardian #1			Parent/Guardian #2		
Legal Last Name:	Legal First Name:	MI:	Legal Last Name:	Legal First Name:	MI:
Phone #1:	Phone #2:		Phone #1:	Phone #2:	

Diagnosis:

Date of Diagnosis:	Diagnosis:
Signs & Symptoms:	

Treatment/Adaptations Needed: List specific needs/steps to follow when child's medical condition presents (i.e. when to give medication(s), medical emergency plan, when to call parents/guardians, etc.)

Notify Parent if:	
Call 911 if:	

Medications: please list all medications student is taking

Medication Name:	Strength:	Dose:	Time:	Route:	Possible Side Effects:	Home/School:

Types of Limitations:

☐ No Limitations
☐ Physical Education (specify):
☐ Playground (specify):
☐ Machinery Operation:
☐ Other (specify):

Physician's Authorization: I authorize the above plan to be followed at school

Physician's Printed Name:	Signature:	Date:

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

- I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
- I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
- If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
- I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
- I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
- I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s).
- **Transportation: It is the parent's responsibility to notify the transportation company directly of any specific directions for your child's care while riding transportation during the school day**

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature ______________________________ Date ______________

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at any time in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: