



**RIVERVIEW COMMUNITY SCHOOL DISTRICT**

13425 COLVIN, RIVERVIEW, MI 48193

Forest Elem: (734)479-2550 | Huntington Elem: (734)283-4820 | Memorial Elem: (734)285-4080 | Seitz MS: (734)285-2043 | RCHS (734)285-7661  
Forest Fax: (734)479-2912 | Huntington Fax: (734)285-6650 | Memorial Fax: (734)285-9058 | Seitz Fax: (734)285-6649 | RCHS Fax: (734)285-6598

**MEDICAL MANAGEMENT PLAN**

**STUDENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_ **TEACHER:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**CONDITION:** \_\_\_\_\_

**SYMPTOMS AND CONSEQUENCES:** \_\_\_\_\_

**MEDICAL MANAGEMENT ACTIONS:**

IF THIS:	PERFORM THIS ACTION:

**EMERGENCY PROCEDURES:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**GENERAL SAFETY RECOMMENDATIONS AND RESTRICTIONS**

**CLASSROOM:** \_\_\_\_\_

**CAFETERIA:** \_\_\_\_\_

**PLAYGROUND/GYM:** \_\_\_\_\_

**FIELDTRIPS:** \_\_\_\_\_

**TRANSPORTATION:** \_\_\_\_\_

**OTHER:** \_\_\_\_\_

**HEALTHCARE PROVIDER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**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 their identified health care needs.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_