



Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Health Management and Emergency Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ City _____ Zip Code _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

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

Medication	Dose	Time	Comments	Expiration date

*All over the counter medications must be in the original container.

*All prescription medications must be in a properly labeled pharmacy box/bottle.

- OVER -

Student Name: _____ Student DOB: _____

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 _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____

Provider NPI # _____

By signing this form you are acknowledging this medication/Health plan is medically necessary for school