Health Management Care Plan

A physician should complete the information on this page.
A parent should complete page 2.

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:

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

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. 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.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the Lic. School Nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick the medication(s) up from the office.

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

Parent/Guardian Signature ____ Date ______________________

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. 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).
3. 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.

Parent/Guardian Signature ___________________________________ Date ____________________________

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

Printed Name:	Signature:	Date: