For office use: Notified/Copy Given To: Classroom Teacher _____ PE Teacher _____ Other _____
Teacher Initials _____ PE Teacher Initials _____

School Health Management Plan

Directions: Please use this form for chronic medical conditions other than asthma, allergies/anaphylaxis, diabetes, and epilepsy.

Child's Name	**DOB**	**Grade**
Parent(s)/Guardian(s)	**School/Teacher**	
Parent/Guardian Phone Numbers **Home:** **Work:**	**Cell:**	
Emergency Contact (other than Parent/Guardian)	**Emergency contact phone:**	
Physician/Phone	**Hospital/Phone**	

Child's Medical Condition: _____

Usual Symptoms:

_____

_____

_____

Frequency of symptoms:

_____

_____

_____

Limitations:_____

_____

_____

Other Comments:_____

_____

_____

WHAT SHOULD SCHOOL STAFF DO TO CARE FOR YOU CHILD'S MEDICAL CONDITION

(PLAN OF ACTION)

1. _____
2. _____
3. _____
4. _____
5. _____

**continued next page

PARENT AUTHORIZATION FOR CARE:

- I UNDERSTAND THAT SCHOOL PERSONNEL WILL MAKE GOOD FAITH EFFORTS TO PROVIDE MEDICAL CARE TO MY CHILD AND ACKNOWLEDGE SCHOOL PERSONNEL WILL NOT BE HELD LEGALLY OR FINANCIALLY RESPONSIBLE FOR THIS CARE.
- I WILL NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN MY CHILD'S HEALTH STATUS OR MEDICATIONS.
- I GIVE PERMISSION TO SCHOOL PERSONNEL TO CONTACT MY CHILD'S PHYSICIAN AS NEEDED; AND THAT EDUCATION/HEALTH INFORMATION MAY BE SHARED WITH STAFF WHO NEED TO KNOW.

PARENT/GUARDIAN SIGNATURE OF APPROVAL (REQUIRED): _____DATE:_____

****If your child requires medication for his/her condition, please fill out the following authorization and bring medication to school. Medication must be in its original containers with label attached- small containers preferred.**

Medication Authorization:

Medication: _____ Strength: _____ How Many: _____Time to give at school: _____

Route (Circle one: By mouth Inhaled/nasal Apply to Skin Apply to eyes Drop into ears Other:_____)

Instruction for use: _____

Medication side effects: _____

Other Information staff should know about student and this medication:

_____

Medication: _____ Strength: _____ How Many: _____Time to give at school: _____

Route (Circle one: By mouth Inhaled/nasal Apply to Skin Apply to eyes Drop into ears Other:_____)

Instruction for use: _____

Medication side effects: _____

Other Information staff should know about student and this medication:

_____

I GIVE PERMISSION FOR DICKINSON PUBLIC SCHOOL PERSONNEL TO ADMINSTER THE ABOVE-NAMED MEDICATION(S) TO MY CHILD; I also acknowledge that school personnel will not be held legally or financially responsible for the administration of this medication(s).

Parent/Guardian signature of Approval (Required): _____ Date: _____

Physician or Health care provider signature (required for any medications): _____

*Form valid for one year from date of signature unless changes in medical status.