

HEALTH MANAGEMENT PLAN

Student: _____ Grade: _____ Teacher: _____

Medical Diagnosis: _____ DOB: _____

Physician and Phone number: _____

Medications: _____

Emergency contacts: _____

Date of Onset: _____

PERTINENT INFORMATION:

MANAGEMENT GOALS:

DAILY MANAGEMENT:

INDIVIDUAL PLAN OF CARE:

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med.	Medication	Dosage & Time given	Common Side Effects & Special Instruction
yes no			
yes no			
yes no			
yes no			

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: _____

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____