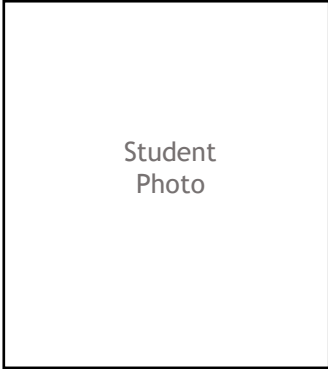




Medical Management Plan

Student Name: _____ Birthdate: _____



Health Condition Diagnosed: _____

Date of Last Review of Plan: _____

Parent Name: _____ Phone (h): _____

Address: _____ Phone (c): _____

_____ Phone (w): _____

Parent Name: _____ Phone (h): _____

Address: _____ Phone (c): _____

_____ Phone (w): _____

Healthcare Providers: _____ Ph: _____

_____ Ph: _____

Emergency Response

Emergency Contact #1	_____	_____	_____
	Name	Relationship	Telephone

Emergency Contact #2	_____	_____	_____
	Name	Relationship	Telephone

Describe signs or situations that indicate an emergency response is needed.



Medical Management Plan

List steps to take in the event of an emergency related to this condition.

Symptoms

List symptoms of the condition that this student is experiencing or may experience, and strategies for managing these symptoms.

Medications

Provide information about medications this student is taking, including dosage and location for any medications to be given at school. List current or possible side-effects of those medications.

Name	Amount	When to use	Side-effects
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Monitoring

List symptoms or symptoms that may indicate the condition is not under control or that medication needs to be adjusted. Identify specific steps the student or teacher should take to monitor this condition.



Medical Management Plan

Triggers and Restrictions

List any foods, activities, situations, etc. that this student should avoid.

Accommodations and Special Considerations

List any adaptations or strategies that will assist this student in participating as fully as possible.

Healthcare Provider

Date

Parent Signature

Date