HEALTH MANAGEMENT PLAN
GENERIC
SCHOOL YEAR: _____

Student Name:	**DOB:**
School:	**Student ID:**
CONTACTS:	
MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

BASIC INFORMATION:

Student history:_____
_____

Medications (list all medications taken):	**Dose:**	**Time:**

SCHOOL MANAGEMENT:

-
-
-
- Other: _____
  _____

CALL PARENTS:
CALL 911:

School Clinic: Copy of this plan should be provided to Transportation Supervisor.

_____ _____

PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.

Rev. 12/2015