# 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:**

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- 
- 
- Other: _____

_____

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|---|
| **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