HEALTH MANAGEMENT PLAN
GENERIC
SCHOOL ¥EAR: _____

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 aU 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 I DATE** _____

Confidentiality of student heath information should be maintained at all times.

Rev. 12/2015