ISD #728 School Health Services
HEALTH MANAGEMENT CARE PLAN

Physician: Please complete this page **Parent/Guardian: Please complete page 2**

Student _____ Date of Birth_____ Grade_____
School _____ Teacher_____

Physician: _____
Parent/Guardian _____ H#_____ W# _____ C# _____
Parent/Guardian _____ H#_____ W# _____ C# _____

Diagnosis: _____Date of diagnosis:_____

Signs and symptoms:_____

_____

TREATMENT/ADAPTATIONS NEEDED WHILE AT SCHOOL AND ON FIELD TRIPS

List specific needs/steps to follow when child's medical condition presents (i.e. when to give medication(s), medical emergency plan, when to call parents/guardians, etc.):

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Notify Parent if: _____

_____

Call 911 if: _____

If student needs immediate medical attention, 911 will be called.

Medications

Medication	Strength	Dose	Time	Route	Possible Side Effects	Home	School
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐
_____	_____	_____	_____	_____	_____	☐	☐

TYPES OF LIMITATIONS

☐ **No Limitations**
☐ **Physical Education (specify):_____**
☐ **Playground (specify):_____**
☐ **Machinery Operation (specify):_____**
☐ **Other (specify):_____**

Physician Authorization

I authorize the above plan to be followed in school.

Physician's Signature: _____ Printed Name of Physician: _____ Date: _____

Parent/Guardian: Please complete back page.

Parent/Guardian: Please complete this page

Student _____ Date of Birth_____ School _____ Grade_____

BUS INFORMATION: Bus cards are no longer being mailed out. ISD 728 will inform the bus company that your child has a medical action plan on file with the Health Office. Please notify the bus company directly of any specific directions for your child's care while riding the bus.

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: _____ Relationship to Student: _____ Date: _____

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR ACTION PLAN

I understand that this action plan may be revoked at anytime in writing, and expires in one calendar year.
I authorize the above plan to be followed in school.

Parent/Guardian Signature: _____ Date: _____