



# HEALTH MANAGEMENT PLAN FOR

STUDENT:  
SCHOOL:

DOB:  
SCHOOL YEAR:

<b>CONTACTS:</b>	
MOTHER:	FATHER:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:

EMERGENCY CONTACTS:	
1.	
2.	
PHYSICIAN:	PHONE:
HOSPITAL PREFERENCE:	

BRIEF HISTORY / MEDICATIONS:
------------------------------

SYMPTOMS:
-----------

TREATMENT:
------------

CALL PARENT IF:
-----------------

CALL 911 IF:
--------------

TRANSPORTATION PLAN:
----------------------

Parent Signature  
Revised 4/03

Date

Nurse Signature

Date

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential and all efforts to maintain this is very important.