HEALTH MANAGEMENT PLAN

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 AND STUDENT HISTORY:
MANAGEMENT:

CALL PARENTS IF:
CALL 911 IF:

Copy of this plan has been provided to Transportation Supervisor Yes □ No □

_____ _____

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 5/10