

Individualized Student Medical Management Plan for 20 _____ - 20 _____ School Year

This student has a medical condition which may require special treatment or care during the school day. The information below is requested in order to assist school personnel to best meet their needs. Please attach any additional information if needed.

This section to be completed by parent

Student's Name _____ DOB _____ Age _____

School _____ Grade _____ HR Teacher _____

Significant Medical History _____

Allergies _____

Treating Physician _____ Phone _____ Fax _____

Parent/Guardian _____ Phone _____

Parent/Guardian _____ Phone _____

This section to be completed by physician

Medical Diagnosis _____

| Current Medications: | Name | Dose | Frequency | Time(s) |
|----------------------|-------|-------|-----------|---------|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |

Medications needed at school (Please include specific time or indications for medications):

Treatments and or Procedures needed at school: _____

Physical limitations (include circumstances under which student may require assistance): _____

Assistive devices/equipment used or needed at school: _____

Early signs and symptoms of illness that may necessitate absence from school: _____

Circumstances in which the physician should be contacted: _____

Other considerations including educational concerns: _____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____ IHP