School-Based Medical Needs Management Plan

To be completed by Physician

Student Name: _____ Birth Date: _____ School: _____

Medical Disorder Type: _____

Date of most recent episode: _____

What happens during an episode: _____

_____

Warnings or behavior changes before an episode occurs? _____

_____

Medications taken for condition (if any): _____

_____

Recommended limitations in school-related activities: _____

_____

ACTION FOR MINOR REACTION

1. If symptom(s) are: _____

   Physician's Instructions: _____

   _____

To be completed by Parent

2. Then call: Parent/Guardian: _____ Daytime phone number _____

   If unable to contact Parent/Guardian call:

   Emergency Contact: _____ Daytime phone number _____

ACTION FOR MAJOR REACTION

1. If symptom(s) are: _____

   Physician's Instructions: _____

   _____

To be completed by Parent

Then call: Parent/Guardian: _____ Daytime phone number _____

If unable to contact Parent/Guardian call:

Emergency Contact: _____ Daytime phone number _____

Note: Even when not included in instructions, school staff may make a decision to call 911 in what is believed to be an emergency situation.

Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

School Representative Signature _____