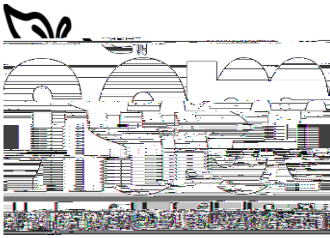

If student requires 911 services, transport to __________________Hospital and contact parents/guardian.

DAILY MANAGEMENT PLAN:

____

1. What medication is taken daily?

   Name: __________________ Dosage: ____________ Time of Day: ______________

   Name: _________________ Dosage: ____________ Time of Day: _______________

2. Has your child ever been hospitalized for this medical condition? Yes _____ No ______ If so, when? ________________

3. Are there activities or stressors that increase the incidence? ________________________________

4. List the activities in which your child can not participate: ________________________________

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

This information will be shared with appropriate school staff unless you state otherwise.

____ ____________________

Parent/guardian Signature Date

____ ____________________

School Nurse Signature Date