School District of Manawa

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 596-5841
Health Aide MES Kris Thompson|(920) 596-5735
Health Aide LWJSHS Sandy Dunnihoo|(920) 596-5845
Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

Health Condition Management Plan 2017/2018

Student Name _____ Date of Birth _____

School _____ Teacher _____

Student ID # _____ Grade _____

Home Street Address_____

City_____ State _____Zip Code_____

Parent/Guardian Name _____

Parent/Guardian Name _____

Please keep all parent/guardian and emergency contact information current with school office staff. In the event of an emergency we will attempt to contact parents/guardians followed by emergency contacts in the order on file.

Section 1: Health Information

Medical diagnosis/health concern:

_____
_____
_____

Describe situation(s) that may require intervention by school staff: _____

_____
_____
_____

Describe what intervention(s) should be taken: _____

_____
_____
_____

Describe situation(s) that may require emergency action: _____

_____
_____
_____

Describe what action(s) should be taken in an emergency situation: _____

_____
_____
_____

Turn Over

Section 2: Medication

Will your child need medication(s) at school for the above health condition? ☐ YES ☐ NO

If the medication will be required daily, a medication administration consent form will need to be filled out. If the medication is only required for an emergency situation, fill in the box below and bring in the medication in its original container with medication label and student's name affixed.

Medication Name	Dose (amount)	Frequency/Timing	Route	Special Instructions

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
5. School staff interacting directly with my child may be informed about this health care plan.
6. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.
7. Hold without liability the School district of Manawa, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the 2017/2018 school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____