School District of Manawa
"Students Choosing to Excel, Realizing Their Strengths"
800 Beech Street | Manawa, WI 54949 | (920) 596-2525
District Fax (920) 596-5308 | Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

HEALTH CONDITION MANAGEMENT PLAN

School Year _____

Student's Name: _____ Birth Date ___/___/_____ Age _____ Grade _____

School Attending: ☐ Elementary School • Phone (920) 596-5700 • Fax (920) 596-5339 Teacher/Advisor _____

☐ Little Wolf Jr/Sr HS • Phone (920) 596-5800 • Fax (920) 596-2655 Teacher/Advisor _____

PARENT • GUARDIAN • EMERGENCY CONTACT

Parent / Guardian 1	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -
Parent / Guardian 2	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -
Emergency Contact 3	Name		Relationship	Phone	( ) -
	Workplace			Work Phone	( ) -

MEDICAL DIAGNOSIS / HEALTH CONCERN

SITUATION(S) REQUIRING INTERVENTION BY SCHOOL STAFF

INTERVENTIONS / ACTIONS TO BE TAKEN

SITUATION(S) THAT MAY REQUIRE EMERGENCY ACTION

INTERVENTIONS / ACTIONS TO BE TAKEN IN EMERGENCY SITUATIONS

MEDICATION

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

If the medication will be required daily, an Administration of Medication Consent form will need to be completed. If the medication is only required for an emergency situation related to this health condition, provide the information below and bring in the unopened and labeled medication in its original container with the pharmacy medication label affixed to it.

Medication Name

Type/Name	Dosage	Frequency/Timing	Special Instructions/Negative Side Effects
Other, specify			

CONSENT FOR MANAGEMENT OF HEALTH CONDITION AT SCHOOL OR SCHOOL-SPONSORED ACTIVITIES

I, the parent/legal 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. Further, I agree to:

1. Provide necessary supplies & equipment in original pharmacy labelled container and/or manufacturer's packaging and within the expiration date.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify school staff or school district nurse; complete new forms for any changes in the student's health status, orders from the student's health care provider, etc.
4. Ensure this form is signed by the appropriate medical provider who manages the medical condition, prescription and/or in doses that exceed the manufacturer's recommended dosages for non-prescription medications or over-the-counter (OTC) medications.
5. Authorize designated school staff or school nurse to communicate directly with primary care provider or specialist regarding health condition & medication.
6. Authorize school staff interacting directly with my child to be informed about this health care plan.
7. Submit new forms annually if the health condition and/or need for medication still exists or inform the school that the condition no longer exists and provide documentation of such, if deemed necessary.
8. 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/Legal Guardian Signature _____ Date _____

Student signature is required if student is 18 years old or attaining 18 years old during the school year

Student Signature _____

Date _____

PRIMARY CARE PHYSICIAN INFORMATION / SIGNATURE

Print Name _____ Phone _____

Medical Facility _____ Fax _____

Address _____ Physician Signature _____

City, State, Zip _____ Date _____

School RN Signature _____ Date _____