

GENERAL MANAGEMENT PLAN

Student Name _____ Birthdate _____ Grade/Teacher _____

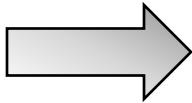
School Name _____ School Year _____

1. Health Condition: _____
2. When was your child diagnosed with the health condition: _____
3. Date of last medical evaluation: _____
4. Name of physician following health condition: _____
5. Please describe your child's condition and how you would like us to manage it a school:

- Restrictions or precautions: _____
- Self Esteem/Coping: _____
- Therapies or treatments (physical therapy, counseling): _____

- Medications: _____
- Other: _____

If you see this (Describe Symptoms):



Do this (List actions to take):

If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

School Nurse Signature _____ Date Reviewed _____