MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

(Must be filled out completely by Physician/Healthcare Provider) This document serves as the Medical Management Plan, and Emergency Action Plan

SCHOOL YEAR_____

CONDITION: _____

Student Name: _____ DOB: _____ Grade: _____ ALLERGY TO: _____

Parent/Guardian: _____ Phone: _____

Physician/ Provider: _____ Phone: _____ Fax: _____

SYMPTOMS

Symptom's student may exhibit:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Other _____

MANAGEMENT

Medications at home: ☐ Yes (If yes, please specify): _____
☐ No

Medications at School: ☐ Yes (If yes, please specify): _____
☐ No

Special Equipment Needed at School: ☐ Yes (If yes, please specify): _____
☐ No

Dietary Modifications/Food Allergies: ☐ Yes (**If yes, please see reverse side.**)
☐ No

Limitations: ☐ Cleared without limitation including all PE, physical activity, and recess.
☐ **NOT CLEARED** for _____

EMERGENCY PLAN

The following symptoms are considered an emergency for this student:

- _____
- _____
- _____

School Personnel should immediately:

☐ **Call 911**
☐ Contact Parent/Guardian
☐ Other instructions (specify): _____

_____
Physician/Provider Signature (Required) **Date:**

_____
Parent/Guardian Signature (Required) **Date:**

_____
School Nurse Signature (Required) **Date:**

Copies Given to:

_____**Parent** ___**Teacher** _____**1st** _____ **2nd** _____ **3rd** _____**4th** ____**5th**____ **6th** ____ **7th**

_____ **PE**___ **Cafeteria**___ **Spanish** ___**Music**___**Art** _____ **ESE**___ **Coach** _____ **HS Teachers**

_____ **Other:** _____

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Student Name: _____ DOB: _____ Date: _____

Parent Name: _____ Phone: _____

1. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/or accommodation. **A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.**

☐ Participant has a food allergy, not considered a disability. Food preferences are not an appropriate use of this form. Please note the food to be omitted below so the participant's meal account can be noted. **A medical authority's signature is not needed and a parent/guardian may complete this form.**

2. The participant's disability or medical condition requiring a special meal or accommodation:

3. If participant has a disability, provide a brief description of his/her major life activity affected by the disability (e.g., Allergy to peanuts causes life-threatening reaction):

4. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

5. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):

A. Foods To Be Omitted	B. Suggested Substitutions

6. Signature of Recognized Medical Authority*	7. Printed Name	8. Telephone Number	9. Date
10. Signature of Parent or Guardian	**11. Printed Name**	**12. Telephone Number**	**13. Date**

***For this purpose, a recognized medical authority is a licensed physician, physician assistant, or nurse practitioner.**

Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.