MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

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

School Year: _____

CONDITION: _____

Scholar Name: _____ DOB: _____ Grade: _____ ALLERGIC TO: _____

Parent/Guardian: _____ Phone: _____

Physician/Provider: _____ Phone: _____ Fax: _____

DIAGNOSIS (w/CPT-ICD-10-CM Code): _____

SYMPTOMS:

Symptoms scholar may exhibit:

☐ _____
☐ _____
☐ _____
☐ _____

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

If Orthopedic Device is needed, please fill out the following form:
"Orthopedic Injury Assistive Device Form"

Dietary Modifications/Food Allergies: ☐ Yes (If yes, please specify): _____
☐ No

*If Dietary Modifications, **of any kind**, are requested, please fill out the following form:*
"Medical Statement to request Special Meals and/or Accommodations"

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

Urinary / BR Modifications: ☐ No
☐ Yes (please specify): BR break every: ☐ 1 hour ☐ 1-2 hours ☐ 2 hours ☐ 2-3 hours ☐ 3 hours ☐ 3-4 hours

EMERGENCY PLAN

The following symptoms are considered an emergency for this scholar:

- _____
- _____
- _____

School Personnel should immediately:

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

COMMENTS:

_____

_____

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 ☐ 8th
☐ PE ☐ Cafeteria ☐ Foreign L. ☐ Music ☐ Art ☐ ESE ☐ Coach ☐ HS Teachers ☐ Other: _____