EDMOND PUBLIC SCHOOLS

Other Conditions Medical Management Plan

Student Name: _____ **Date of Birth: _____** **School year: _____**

School: _____ **Teacher: _____** **Grade: _____**

Parent/Guardian: _____

Home Phone: _____ Work phone: _____

Emergency Contact: _____

Home Phone: _____ Work Phone: _____

Physician: _____ Phone: _____

Health Condition: _____

Characteristics of Health Condition: _____

_____

_____

Date of Onset: _____

Special Instruction at School: _____

_____

_____

_____

_____

_____

Notify parent/guardian or emergency contact in the following situation: _____

_____

_____

_____

I give permission to the school nurse and other staff members of _____ School to perform and carry out the emergency care tasks as outlined by _____'s Medical Management Plan. I also consent to the release of the information contained in this Medical Management Plan to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____

Parent/Guardian Signature Date

Acknowledged & Received by:

_____

School Nurse Date

Revised 10/2013