MADISON COUNTY SCHOOLS **SCHOOL YEAR** _____

SCHOOL MANAGEMENT PLAN: OTHER MEDICAL CONDITION

FOR THE FOLLOWING MEDICAL CONDITION: _____

Section I - Parent

Student Name: _____ DOB: _____ School/Grade: _____

Known Allergies/Triggers: _____ Wt. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. _____

Parent Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

Section II – (Please Print):

IF YOU SEE THIS…	**DO THIS…**

ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.
I give permission for the release of my child's medical information, in the event of an emergency.

_____ Physician/Prescriber's Signature _____ Date

_____ School Nurse's Signature _____ Date

_____ Parent's Signature _____ Date

_____ Staff Signature (s) _____ Date

FOR SCHOOL NURSE USE ONLY

Medication	Self-Carry?	Self-Administer?	Expiration	Location of Medication

Revised 05/2013