Perry Township Schools General Medical Management Plan

NAME:	Student Name	DOB:	Student Birthdate	SCHOOL:	School Name
PARENTS:	Guardian(s) Primary				
ADDRESS:	Guardian(s) Primary Address Box				
PHONE:	Guardian(s) Primary Phone				
1. PHYSICIAN(S) / HEALTHCARE PROVIDER(S) - List specialty, phone number, fax number, email address:					
2. OTHER EMERGEN	CY CONTACT(S) - List name, relationship, phor	ne number:			
3. PRIMARY DIAGNO	OSIS AND ALLERGIES (if applicable):				
4. MEDICATION(S) -	List drug, dose, route, time or frequency of admi	inistration:			
5. ROUTINE NURSING	GCARE TO BE PERFORMED AT SCHOOL - List	nursing care, time	, student's level of indepe	endence (self-care, need	ds supervision, total care):
6. EMERGENCY CAR	E (if applicable) - List details:				
7. UNLICENSED PERS	SONNEL TO BE TRAINED - List name, title, type a	and date of training	ı:		
8. EQUIPMENT/SUPP	LIES TO BE KEPT AT SCHOOL (Provided by par	rent/guardian):			
IHP written by:			Clinic assistan	t: _	Date: Todays Date
O-1 O-1-1-1/O	Nurse's signature and title	•			
Cc: School/Caregiver	and ParenvGuardian				
X					
	OF PARENT OR GUARDIAN				
Addendum: Pertinent MD orders and two-way release included in student's Skyward health records as needed.					