FOR OFFICE USE: Notified/Copy Given To: Classroom Teacher _____ PE Teacher _____ Other _____

Teacher Initials _____ PE Teacher Initials _____ BPS-SE 42d 05/18

BPS School Health Management Plan

Directions: Please use this form for chronic medical conditions other than asthma, allergies/anaphylaxis, diabetes and epilepsy.

Child's Name	**DOB**	**Grade**
Parent(s)/Guardian(s)	**School/Teacher**	
Parent/Guardian Phone Numbers: Home:	**Work:**	**Cell:**
Emergency Contact (Other Than Parent/Guardian)	**Emergency Phone**	
Physician/Phone	**Hospital/Phone**	

CHILD'S MEDICAL CONDITION: _____

Usual symptoms:

_____

_____

_____

Frequency of symptoms:

_____

_____

_____

Limitations:_____

_____

_____

Other Comments:_____

_____

_____

_____

WHAT SHOULD SCHOOL STAFF DO TO CARE FOR YOUR CHILD'S MEDICAL CONDTION

(Plan of Action)

1._____
2._____
3._____
4._____
5._____

(Continued on Back Side)

PARENT AUTHORIZATION FOR CARE:

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to School personnel to contact my child's physician as needed; and that education/health information may be shared with staff who need to know.

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

If your child requires medication for his/her condition, please fill out the following authorization and bring medication to school. Medication must be in its original container with label attached– small containers preferred

MEDICATION AUTHORIZATION:

Medication:_____ Strength:____ How Many:____ Time to give at school:____

Route (*Circle One*: By mouth Inhaled/nasal Apply to Skin Apply to eyes Drop into ears Other:_____)

Instruction for use:_____

Medication side effects:_____

Other information staff should know about student and this medication:_____

_____

Medication:_____ Strength:____ How many:____ Time to give at school:____

Route (*Circle One*: By mouth Inhaled/nasal Apply to skin Apply to eyes Drop into ears Other:_____)

Instruction for use:_____

Medication side effects:_____

Other information staff should know about student and this medication:_____

_____

I give permission to Bismarck Public School personnel to administer the above named medication(s) to my child; *I also acknowledge that school personnel will not be held legally or financially responsible for the administration of this medication(s).*

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

Form valid for one date from date of signature unless changes in medical status.