HEALTH ROOM USE ONLY HR___
Medication supply at school_____ PE___
Parent conference_____ Other __

Special Medical Condition Plan School Year_____

Name_____ Grade/room_____
Parent/guardian_____
Home phone_____ Work phone_____
Cell phone_____Other contact_____Phone_____
Physician_____ Hospital preference_____

Medical condition _____

History of medical condition:
Year of diagnosis or at birth_____
Surgeries/hospitalizations and dates (year) If more space needed, please use back of form:_____
_____
_____

Current medications

Name time dosage

_____
_____
_____

**If medication is needed to be given at school, even an emergency medication, please contact the school nurse for forms and procedure.

Medical emergencies with this condition (your child's specific symptoms) and how you want the school to treat these issues (observe, call parent, give medication or treatment, call 911, etc.)

Symptom/issue Treatment

_____
_____
_____
_____
_____

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Medication supply at school_____ PE___
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Any other special care/notifications/restrictions needed at school for this condition:

(Adaptive gym or no gym requires an order from your physician, contact the school nurse or physical education teacher for form)

_____

_____

_____

_____

Parent signature_____ Date_____