HAWTHORN SCHOOL DISTRICT #73
Vernon Hills, IL 60061

HEALTH MANAGEMENT PLAN

(To be completed by parent - please use black ink)

School Year __________ to ___________

Student ________________________________ Grade ____________ Teacher____________________

Mother ______________________ Phone ___________ Father ___________________ Phone ___________

Physician _________________________________ Phone __________________

MEDICAL CONDITION: ____

SYMPTOMS STUDENT MAY REPORT: ____

PHYSICAL SIGNS: ____

MEDICATION	DOSE/ROUTE	TIME	POSSIBLE SIDE EFFECT

PREVENTION: ____

EMERGENCY CARE: ____

ACTIVITY MODIFICATIONS: ____

DIETARY ADAPTATIONS: ____

OTHER CARE: ____

INSTRUCTIONS:

❒ If school is unable to reach parents in an emergency, permission is granted to contact physician.

❒ I agree to release this information to the following staff, as appropriate, with the expectation that confidentiality will be respected at all times:

❒ Nurse
❒ Teachers
❒ PE Staff
❒ Bus personnel
❒ Recess staff
❒ After school caregiver/coaches
❒ Other ____

Parent Signature____ Date _________________

File: Permanent Health Record