Wrightstown Community School District

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 532-0525 ext. 5016
Health Aide WES Erica Pivonka |(920) 532-4818 ext. 2010| Health Aide WMS Ashley La Roque|(920) 532-5553 ext. 4108
Elementary School Fax (920) 532-4664 |Middle School Fax (920) 532-3869 | High School Fax (920) 532-0860

Health Condition Management Plan for School Year: _____

Student Name _____ Date of Birth _____

School Building _____ Teacher _____Grade _____

Parent/Guardian Name and Phone Number(s)_____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

Section 1: Health Information

Medical diagnosis/health concern:

_____
_____
_____

Describe situation(s) that may require intervention by school staff: _____
_____
_____
_____

Describe what intervention(s) should be taken: _____
_____
_____
_____

Describe situation(s) that may require emergency action: _____
_____
_____
_____

Describe what action(s) should be taken in an emergency situation: _____
_____
_____
_____

Turn Over

Section 2: Medication

Will your child need medication(s) at school for the above health condition? ☐ YES ☐ NO

If the medication will be required daily, a medication administration consent form will need to be filled out. If the medication is only required for an emergency situation related to this health condition, fill in the box below and bring in the medication in its original container with pharmacy medication label affixed.

Medication Name	Dose (amount)	Frequency/Timing	Route	Special Instructions/Negative Side Effects

Parent consent for management of health condition while at school or other school-sponsored activities

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment, including medication in the original. pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
6. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition.
7. School staff interacting directly with my child may be informed about this health care plan.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. Hold without liability the Wrightstown Community School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the pertaining school year)

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

School RN Signature _____ Date_____