



# Wyandotte Public School's Medical Management Plan



Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Year: \_\_\_\_\_ Teacher: \_\_\_\_\_

Condition: \_\_\_\_\_

Symptoms and Consequences: \_\_\_\_\_

## Medical Management Actions:

IF THIS	PERFORM THIS ACTION

## Emergency Procedures:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Emergency Contacts:

1. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relation to student: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relation to student: \_\_\_\_\_

# General Safety Recommendations and Restrictions

In the classroom: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the cafeteria: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On the playground and in the gym: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On field trips: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

During transportation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Healthcare Provider Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## To be completed by parent/guardian:

I, (parent/guardian), \_\_\_\_\_ request that my child,  
\_\_\_\_\_, receive the above described medical management  
at school according to standard school policy, and for the healthcare provider staff and school staff to  
share information as needed to assist my child with his/her identified health care needs.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_