Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Health Management and Emergency Plan

Student _____ Date _____ Grade_____

Date of Birth _____School _____Teacher _____

Address_____ Parent/Guardian_____

City _____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Section 1: Health Information

Medical diagnosis/health concern: _____
_____
_____
_____

Describe situation that may require emergency action: _____
_____
_____
_____

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

Section 2: Medication

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

√ if an Emergency Medication	Medication	Dose	Time	Comments

- OVER -

Section 3: Hospital Information

If a parent/guardian or emergency contact cannot be reached, I authorize school staff to call 911 and transport my child to _____ Hospital for medical care.

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

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature_____ Date_____

Physician Information

Print Name of Provider_____ Clinic Name _____
Phone Number_____ Fax Number _____
Address _____

Signature of Provider_____ Date_____