KAPS HEALTH MANAGEMENT PLAN

Student Name: _____ Grade: _____ Teacher: _____

Medical Diagnosis: _____ DOB: _____

Physician and Phone number: _____

Medications: _____

Emergency contacts: _____

_____

Date of Onset: _____

PERTINENT INFORMATION:

_____

_____

_____

_____

MANAGEMENT GOALS:

_____

_____

_____

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_____

DAILY MANAGEMENT:

_____

_____

_____

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_____

INDIVIDUAL PLAN OF CARE:

_____

_____

_____

_____

Treatment Protocol During School Hours (include daily and emergency medications):

_____

_____

_____

Emergency Medication?		Medication	Dosage & Time Given	Common Side Effects & Special Instructions
◯ Yes	◯ No			
◯ Yes	◯ No			
◯ Yes	◯ No			
◯ Yes	◯ No			
◯ Yes	◯ No			

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

_____

_____

_____

_____

_____

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____