Vale School District 403 E Street West Vale, OR 97918

Health Management Plan

Printed student name:____
Birthdate Grade

Address:____
City State Zip

Parent/Guardian:____
Printed name Phone (H) (W) Cell

Parent/Guardian:____
Printed name Phone (H) (W) Cell

Physician:____
Phone

- Medical Condition that may affect student at school:_____________________________
- Describe symptoms:____
  Please give date of last episode

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- Describe procedure to follow if an episode occurs at school:

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If medications are needed, they must be provided by parent.
I authorize the school nurse to contact the listed physician as needed regarding this medical condition.
I understand that this plan will be shared with school staff as determined necessary by school nurse.

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Parent/Guardian Signature Date