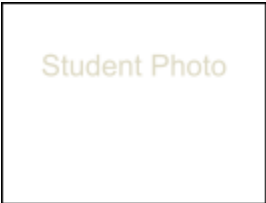


Management of Medical Concerns



STUDENT NAME: _____

CLASSROOM: _____

MEDICAL DIAGNOSIS: : _____

DATE EFFECTIVE: _____

Student wears a medical alert: Yes No

Nature Of Treatment	Signs & Symptoms	Facilitating Daily/Routine Management At School
		<p style="text-align: center;">If additional space is required, please use the reverse side.</p>

I/We authorize the Principal or Principal Designate to share this plan of care with school staff who are in direct contact with my/our child. For example, the classroom teacher, educational assistants, rotary teachers, occasional staff, appropriate Holland Bloorview Kids Rehabilitation Hospital staff, and volunteers.

Other individuals to be contacted regarding this plan of care: _____

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent’s responsibility to notify the principal if there is a need to change this plan of care for Management of Medical Concerns during the school year.

Signature of Parent/Legal Guardian

Signature of Health Care Professional (Physician, Nurse Practitioner)

Phone Number(s) _____
Date

Phone Number(s) _____
Date