



WOODHAVEN-BROWNSTOWN SCHOOL DISTRICT

Learning and Leading for Tomorrow

Special Services

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Matthew Salah, Director
Irene Miekis, Supervisor

District or School Name
Address
Phone and Fax Numbers

MEDICAL MANAGEMENT PLAN

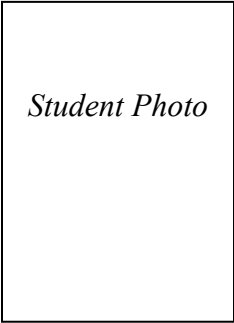
Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Teacher(s):

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:** _____

3. **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:** _____

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 ordering 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:** _____