Merrill Area Public Schools
1111 N. Sales Street Merrill, WI 54452 715.536.4581 Fax 715.536.1788
www.mapsedu.org

* Student Achievement * Community Partnership * Future Success *

HEALTH MANAGEMENT PLAN
School Year: 2023-2024

The student's healthcare provider and parents / guardians should complete this form. Please fill out the entire form. Review with relevant school personnel who have educational and safety interest in students with a health plan. Copies may be shared with the school nurse, trained school personnel and other authorized personnel.

This information will become part of your child's school health record and may be shared with Merrill Area Public School staff, Lincoln County Health Department, bus driver(s) and emergency personnel who are responsible for caring for your child while he / she is attending school, summer school, school based or sponsored events, or in an emergency situation. Lincoln County Health Department does not provide health services or oversight for students during any school-based or sponsored events outside of regular school hours. ("Regular School Hours" are defined as school hours that occur from 8 AM to 3 PM (Monday through Friday) from the first to last day of regular instruction which includes summer school.)

Student Information

Name: _____ **Date of Birth:** _____

Teacher: _____ **Grade:** _____

School Name: _____

Parent/Guardian Contact Information	Telephone
1. _____	1. _____
2. _____	2. _____
Emergency contacts/ Relationship	**Telephone**
1. _____	1. _____
2. _____	2. _____

Health Care Provider	Telephone
1. _____	1. _____
2. _____	2. _____

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HEALTH MANAGEMENT PLAN - Continued
School Year: 2023-2024

Student Information

Name: _____ **Date of Birth:** _____

Medical Diagnosis/Health Condition:

_____

Past/Current Information:

_____

_____

Current Concerns:

_____

Interventions:

_____

_____

If the student will be in a school sponsored sport, the parent / guardian MUST inform / train the Coach of the health condition and treatment plan.

I understand and agree with this health care plan.

Physician Signature (if applicable) _____ Date _____

Parent / Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____