OCONOMOWOC
AREA SCHOOL DISTRICT
EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

General/Generic Health Care Plan

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name ____________________ School Year ____________________
Birthdate ____________________ School ____________________
Practitioner ____________________ Grade ____________________
Practitioner Phone ____________________ Practitioner Fax ____________________

The following information is helpful to your child's District Nurse and school staff in determining any special needs your child might require. Please answer the questions to the best of your ability. If you desire a conference with the District Nurse, please call **262-560-2104** for an appointment.

☐ **The condition(s) listed below are no longer an issue for my child. (Please sign and return Care Plan)**

Medical condition(s): ____
____

Usual treatment: ____
____
____

Medication	Dosage	Time(s)	Taken at home or school

******Please supply the school with the needed medication(s) on or prior to the first day of school******

Should this medication be sent with a District Employee for your child for field trips?
☐ Yes ☐ No
The last week of school, how should medications be returned home?
☐ Sent home with Student ☐ Parent/Guardian Pick-Up

☐ My child does not take any medication at home or at school

Signs of emergency: ____
____

Actions for teacher to take: ____
____

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

⇨ ____
Parent/Guardian Signature **Date**

⇨ ____
Practitioner Signature **Date**