West Bloomfield Schools

General Medical Plan

Student's Name: _____ School Year _____

Date of Birth: _____

Contact Information

First Contact	Second Contact
Name: _____	Name: _____
Relationship: _____	Relationship:_____
Phone (1) _____	Phone (1) _____
Phone (2) _____	Phone (2) _____

DIAGNOSIS

SIGNS & SYMPTOMS

IF SYMPTOMS OCCUR, DO THE FOLLOWING

ADDITIONAL NOTES/INSTRUCTIONS

West Bloomfield Schools

General Medical Plan

Student Name _____ Date of Birth _____

Medication _____ Dosage _____

Time to be given _____ If PRN, allowable frequency _____

Medication _____ Dosage _____

Time to be given _____ If PRN, allowable frequency _____

Physician/Licensed Prescriber Name (Print) _____

Phone Number _____ Fax Number _____

Signature _____ Date _____

I agree with this medical plan as written and for the school staff to share this information with those that need to know and for staff to contact the treating healthcare professional for clarification of this plan, if needed.

Parent/Guardian Name (Print) _____

Signature _____ Date _____

07/10/23