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GRAND BLANC COMMUNITY SCHOOLS

MEDICAL MANAGEMENT INVENTORY ASSESSMENT

Dear Parents/Guardian:

If your child has an allergy or special medical condition that could impact their learning environment, please check the appropriate box below and fill out the attached paperwork. Once completed, please return this page as well as the attached form to the office of the school which your child attends.

If you do not feel that your child's condition or allergy warrants a MMIA, please check the appropriate box below, sign and date this form and return it to the office of the school which your child attends.

☐ I would like my child, _____, to have a Medical Management Inventory Assessment (MMIA) completed. I have completed the attached forms.

☐ I do not feel my child, _____, needs to have a Medical Management Inventory Assessment completed above and beyond normal emergency procedures.

Parent/Guardian Signature: _____

Date: _____

GRAND BLANC COMMUNITY SCHOOLS

MEDICAL MANAGEMENT INVENTORY ASSESSMENT

PLACE STUDENT PHOTO HERE

Name: Birth Date:

Parent/Guardian Name:

Home Phone: Work Phone:

Physician: Physician Phone:

Physician Signature: Date:

Teacher's Name: Student's Bus Number:

Diagnosis:

If your child has these conditions, please check:

- ☐ Epilepsy
- ☐ Anaphylatic Shock
- ☐ Blood Disorders
- ☐ Severe Allergies
- ☐ Severe Asthma
- ☐ ADHD/ADD
- ☐ Diabetes
- ☐ EpiPen Required
- ☐ Other

*A Specific **Medical Action Plan** related to above noted medical condition will be created by designated staff in collaboration with parents, child and physician if applicable. Information in the plan should be shared with appropriate school personnel.*

Parent/Guardian Comments:

If a medical event does occur at school, please check off those actions that apply. Also, please indicate the order in which they should be done.

ORDER

- ☐ [ ] Call 9-1-1
- ☐ [ ] Call parent/guardian at Home:_____ Work: _____ Cell:_____
- ☐ [ ] Call this Emergency Contact: _____Phone: _____
- ☐ [ ] Administer Medication: _____

To request medication be administered at school (regularly or on an emergency basis) please complete the necessary form available in the school office.

Parent Signature:

Administrator Signature: Date Received:

OFFICE USE ONLY

Based on information provide above, the following is recommended *(please check all that apply)*:

- ☐ No additional action and/or plan necessary
- ☐ Medical Plan of Action
- ☐ 504 Plan
- ☐ Food Allergy Plan
- ☐ Referral to Special Services for Additional Support
- ☐ Other:_____