## INFORMAL MANAGEMENT PLAN for SPECIAL MEDICAL/HEALTH NEEDS Student Name: \_\_\_\_\_ Grade: \_\_\_\_ Building: \_\_\_\_\_ This student's medical/health condition is: Supervising Physician: Phone: \_\_\_\_\_ The following accommodations will be put in place: The duration of this plan will be from \_\_\_\_\_\_ to \_\_\_\_\_. On behalf of the school district, I assure that we will implement the plan described above. Signature of Building Administrator: \_\_\_\_\_ Date: \_\_\_\_\_ I agree that the plan described above is appropriate to meet my child's needs and, although I have been advised of my rights under Section 504, I do not wish to pursue a more formal plan through Section 504 at this time. Signature of Parent: \_\_\_\_\_\_ Date: \_\_\_\_\_