

Strongsville City Schools Medical Action Plan

To the parent/guardian of _____

School _____ Grade _____

According to our records your child has been diagnosed with _____

When was your child diagnosed? _____

Identify any triggers/symptoms your child may experience _____

Treatment plan to manage your child's symptoms _____

Medication taken by your child _____

Do you plan to have medication available at school?

YES

NO

Name of medication _____

Medication Administration forms are available from the school clinic, and must be completed before any medication can be administered at school.

Parent/Guardian signature

Date

Parent/Guardian emergency telephone number(s)

Please complete this form and return it to the clinic nurse