MEDICAL HEALTH CARE PLAN

DIAGNOSIS: ____

Student's Name ________________________________ **DOB:** _________________

Teacher: ____________________ **Grade:** __________

Primary Care Provider: _________________________ **Phone:** _______________

Specialty Physician: ______________________________ **Phone:** _______________

Signs/Symptoms of Diagnosis: ____

____

____

*ACTION FOR MINOR SYMPTOMS *

If Symptoms are: ____

____

Procedure: ____

____

Then Call:
Parent/Guardian: ______________________________**Phone:**________________________

*ACTION FOR MAJOR SYMPTOMS *

If Symptoms are: ____

____

Procedure: ____

____

*IF SYMPTOMS ARE LIFE-THREATENING CALL 911 *

Parent/Guardian: ____
Address: ____
Home Phone: __________________**Work:** __________________**Cell:** ________________
Emergency Contact: _____________________________________**Phone:** ______________

Parent's Signature __________________________________**Date** ________________