

HEMOPHILIA ACTION PLAN

STUDENT:		D.O.B
SCHOOL:	GRADE:	TEACHER:
PARENT/LEGAL GUARDIAN:		
PHONE #s: HOME:		WORK:
CELL:		<u>—</u>
Specific Instructions:		
Approve participation in the following		
□Tetherball	□ Volleyball	
☐ Touch Football	☐ Soccer	
☐ Floor Hockey	☐ Dodgeball	
☐ Kickball	☐ Basketball	
☐ Softball		
I,information about my child.	, autho	rize the physician's office to release confidential
Parent / Legal Guardian's Signature		Date
Physician's Signature		Date
Physician's Printed Name		Physician's Phone Number