Confidential Confidential

Student Health Action Plan

Student: ________________________ **Medical Diagnosis:** ____________________________________

Date of Birth: __________________ **Bus Rider: Yes** ____ **Bus Number**____ **No**____

Emergency Contact Numbers:

Number	**Name**	**Relationship**
1.______________________	______________________	______________________
2.______________________	______________________	______________________
3.______________________	______________________	______________________

I hereby give permission for school health officials to dialogue with our physician. Yes or No
Physician Name: ________________________________ **Number:** __________________________

Signs and Symptoms: ____
____

Actions:

If You See These Symptoms	Follow These Actions	Medications/Dosage Amount

Medications will be administered according to the directions listed above. I understand that the Oconee County School System and its employees are not liable for adverse effects on injury due to administering or not administering the above listed medications. The school has permission to seek emergency medical treatment for the student when necessary and appropriate. The nurse has permission to dialogue with school personnel regarding this information and any related issue.

____ _______________________
Parent Signature **Date**

____ _______________________
Physician or School Nurse Signature **Date**

Copies Given To: **Date:**
School Nurse: ________________
Teacher: ________________
Bus Driver: ________________
Administrator: ________________
Activities: ________________

(Rev. 8/07)