OKEMOS PUBLIC SCHOOLS
Medical Information Action Plan

Name: _____ **Birth date:** _____

Parent Name(s): _____

Parent Telephone Info: 1)_____ 2)_____

Teacher: _____ **Physician Name/Phone:** _____

Student's Condition _____

Is this condition life threatening? **YES** **NO**

Describe Condition:

Signs/Symptoms (in detail):

Emergency Procedures/Medical Protocol:

Step 1

Step 2

Step 3

**A separate form should be filled out for each medical condition if a student has more than one.*

Parent: By submitting this signed form, you give permission for this information to be shared with all appropriate school staff who have contact with this child.

Would you like classroom volunteers to have access to this information? YES NO

_____ _____

Parent Signature (required) Date

Physician: Please sign below to indicate that you recommend/agree with the medical protocol stated above.

_____ _____

Physician Signature (required) Date