Medical Concern Action Plan

Name: _____

Date of Birth:_____

Address/Phone/Parents:_____
_____
_____
_____

Primary Doctor:_____

Address/Phone:_____

Principal Diagnosis:_____

Hospital Admissions in the last 12 months
Reason/Outcome/Discharge Date:
1._____
2._____

Current Medications:
Dosage/Frequency/Method of Administration/Reason for taking/Prescribed by/Date started
1._____
2._____
3._____

Allergies:_____

Equipment:
Type of equipment/ date prescribed
_____

Medical History:
Dates of diagnoses/surgeries/hospitalizations/treatments/significant changes
_____
_____
_____

Review of Body Systems:
How does it impact child/treatment/effectiveness

Nutrition/swallowing:_____
Dental:_____

Vision:_____
Cardiac:_____
Hearing:_____
Renal:_____
Communication:_____
Endocrine:_____
Respiratory_____
Gastrointestinal:_____
Orthopedic:_____
Skin Integrity:_____

Potential Problems :
Changes/issues to watch/plan to address changes
_____
_____
_____
_____
_____
_____
_____

Doctor's Signature:_____

Date:_____

Parent signature:_____

Date:_____