



Medical Information Action Plan

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

Student Name _____ Date of birth _____

Parent/Guardian Name(s) _____

Parent/Guardian Telephone Information 1. _____ 2. _____

Students Condition _____ If other please state condition _____

Is this condition life threatening Yes No

Describe condition _____

Signs and symptoms in detail _____

Emergency Procedure/ Medical Protocol

Step 1 _____

Step 2 _____

Step 3 _____

By signing this form, you grant permission for this information to be shared with all appropriate school staff who have contact with your child, in accordance with HIPAA and FERPA regulations. This staff may include teachers, food service staff, before and aftercare staff, and after-school sponsored program staff. The intent of sharing this information is solely to support your child in the event of an emergency.

Would you like classroom volunteers to have access to this information Yes No

Required Parent/Guardian Signature _____ Date _____

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

Required Physician Signature _____ Date _____