Medical Action Plan

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN and PHYSICIAN EACH SCHOOL YEAR

School Year 20____- 20____

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.				
Name of School:				Grade:
Student's Name:		DOB:		
Name of Mother/Legal Guardian:	Employer:	Home Phone:	Work Phone:	Cell Phone:
Name of Father/Legal Guardian:	Employer:	Home Phone:	Work Phone:	Cell Phone:
Name of child's primary care provider or medical specialist:				
Primary care provider/medical specialist phone number:				
Primary care provider/medical specialist fax number:				
Name of medical condition requiring medical action plan:				

PART 2: Please complete section below for medical condition noted above.

SYMPTOMS: Please list any symptoms that school staff should be aware of related to medical diagnosis.

_____

_____

_____

MEDICATION: Please list any medications taken for the above diagnosis.

_____

_____

_____

Special Instructions or Physician Orders:

Please list any special instructions or orders related to above diagnosis that need to be followed while student is at school:

_____

_____

_____

_____

(If more space is needed please attach separate sheet.)

CONTINUE TO REVERSE SIDE

Medical Action Plan

Student Name:	**DOB:**

PART 3: Please sign and return to school nurse.

_____ _____

Parent Signature Date

_____ _____

Physician Signature Date

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE