SHELDON INDEPENDENT SCHOOL DISTRICT
Health Condition Action Plan

Photo

THIS PART TO BE COMPLETED BY PARENT

Student's Name: _____ **Date of Birth** _____ **Age**_____

School_____ **School Year**_____ **Teacher**_____ **Grade**_____

Parents/Guardians Information

Name _____ Phone # _____ Phone # _____

Name _____ Phone # _____ Phone # _____

Emergency Contact Number

Name _____ Relationship_____ Phone # _____

Physician/Health Care Provider _____ Phone # _____

Health Information

Physician Diagnosed Health Condition/s _____

List any medication your child is currently taking _____

List any previous surgeries or hospitalizations _____

List any other important health information _____

I hereby authorize the school, through the nurse or principal designee, to give my child the necessary treatment and/or care as outlined below by the physician and to share information with other school staff members and health care providers on a need-to-know basis. I release Sheldon Independent School District, and any school district employee from any and all liability that may arise related to the treatment and/or care of my child.

Parent/Guardian's Signature: _____ **Date:** _____

THIS PART NEEDS TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medical Diagnosis _____ Exam Date: _____

Brief Description of Medical Diagnosis _____

Activity or Physical Limitations _____

Additional Instructions/Comments while Student is at School _____

Signs and Symptoms of a Medical Emergency—**Call 911 if student is experiencing the following:** _____

If You See This (Signs and Symptoms)	Do This (Action)

MEDICATION OR TREATMENT DURING SCHOOL HOURS

Medication / Treatment	Dosage & Route	Time to be Given	Side Effects/Special Instructions

Physician's Name _____ **Physician's Signature** _____ **Date** _____