



HEMOPHILIA ACTION PLAN

STUDENT: _____ D.O.B. _____

SCHOOL: _____ GRADE: _____ TEACHER: _____

PARENT/LEGAL GUARDIAN: _____

PHONE #s: HOME: _____ WORK: _____

CELL: _____

Specific Instructions:

Approve participation in the following activities by placing a check mark in the box:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Tetherball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Touch Football | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Floor Hockey | <input type="checkbox"/> Dodgeball |
| <input type="checkbox"/> Kickball | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Softball | |

I, _____, authorize the physician's office to release confidential information about my child.

Parent / Legal Guardian's Signature

Date

Physician's Signature

Date

Physician's Printed Name

Physician's Phone Number