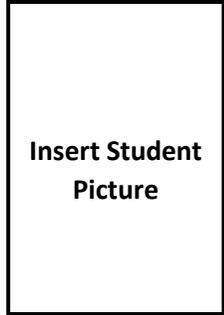


Effective Date: _____



Student Medical Action Plan

STUDENT INFORMATION			
Student Name:		DOB:	Grade:
Parent Name:		Phone:	
Parent Name:		Phone:	
EMERGENCY CONTACT			
Contact Name:		Contact Relationship:	
Phone 1:		Phone 2:	

MEDICAL CONDITION/DIAGNOSIS (CHECK ALL THAT APPLY)	
<input type="checkbox"/>	Allergy (list allergens)
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Other (be specific)

SYMPTOMS/SIGNS TO LOOK FOR TO ADMINISTER MEDICATION
<p>TO BE COMPLETED BY THE PHYSICIAN: <i>Tell us what specific symptoms/signs that staff should look for regarding the child's medical condition in order to know when to administer prescribed medication.</i></p>

TREATMENT PLAN

TO BE COMPLETED BY THE PHYSICIAN: Describe the specific treatment plan that staff should follow when symptoms appear for the child.

MEDICATION AND DOSAGE

List the specific medication and dosage for your child (include daily medications)

Emergency Med	Medication	Dosage	Special Instructions

Does this student need to self-carry medication? Yes† No

Does this student receive district transportation? Yes* No

†If yes, the *Request for Self-Possession/Self-Administration of Medication* form is required to be completed.

*If yes, a copy of this plan must be included on all buses that the student rides.

ADDITIONAL INFORMATION

TO BE COMPLETED BY THE PHYSICIAN OR AT THE SCHOOL ORGANIZATIONAL MEETING: *This space is available for additional pertinent instructions, special considerations, or precautions from either the physician's office or the consultation meeting at school.*

AGREEMENT AND SIGNATURE

By submitting this medical plan, I affirm that the facts set forth in it are accurate and complete.

Parent/Guardian Name: _____ **Signature:** _____

Date: _____

Physician Name: _____ **Signature:** _____

*You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this medical action plan.

Date: _____

Practice Name, Phone, and Address: _____