

HEALTH CARE ACTION PLAN

STUDENT _____ **BIRTHDATE** _____

SCHOOL _____ **GRADE** _____ **ROOM** _____

DESCRIPTION OF ILLNESS OR CONDITION:

INDICATION FOR ACTION:

ACTION REQUIRED, TRANSPORTATION PLAN, AND DEGREE OF URGENCY & EXPECTED OUTCOME:

CALL 911 IF SITUATION WARRANTS.

ANY MEDICAL COST INCURRED IS AT THE EXPENSE OF THE FAMILY.

Dr. _____ **Phone** _____

EMERGENCY CONTACT INFORMATION:

1. _____

2. _____

3. _____

The school nurse may share information with teacher, instructional assistants, food service, bus drivers, etc in the best interest of my student. It is the parent's responsibility to inform extracurricular activities personnel of student's condition

Principal Signature Date

Parent/Guardian Signature Date

Nurse Signature Date

Parent/Guardian Signature Date

Physician Signature if necessary Date