STUDENT MEDICAL ACTION PLAN

Student's Name: _____ Date of Birth: _____

Grade: _____ School: Katherine Anne Porter School Teacher: _____

Emergency Information:

Parent's/Guardian Name:_____

Mother's/Guardian Home Number:_____ Cell Number:_____ Work Number:_____

Father's/Guardian Home Number:_____ Cell Number:_____ Work Number:_____

Physician's Name:_____

Physician's Phone Number:_____

In Case of Emergency Contact:

1. _____
2. _____
3. _____
4. _____

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TO BE FILLED OUT BY A PHYSICIAN

Please give a brief description of the child's health condition and the steps you would like the school personnel to take in case of an emergency with the child.

HEALTH CONDITION: _____

_____

_____

_____

_____

ACTION(S) TO BE TAKEN

1._____

2._____

3._____

4._____

5._____

6._____

Note that if a medication is to be administered during the school day, the medication consent form must also be signed and accompany this form. The correct dosage must be listed on the original bottle or a doctor's order with instruction(s) for the medication must be presented if that's not available. The KAPS nurses are unable to take medication orders from parent(s)/guardian(s).

This information will be shared with the child's classroom teacher, building medication administrator, physical education teacher, and other staff on a need to know basis to ensure safe management of your child's health condition.

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Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

For any questions or changes in this plan, please inform the School Nurse as soon as possible. Thank you.

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