INDIVIDUAL ACTION PLAN FOR MEDICATION AT DARIEN NATURE CENTER

Student's Name: _____ Date of Birth: _____
Physician's Name_____ Physician's Phone #_____

Specific Health care need (please briefly describe):

Steps to Take If Child Needs Medication (number the sequence of action):

___ Observe Child for Signs and Symptoms:

___ Notify Parents of Sign and Symptoms

___Give Medication: _____ Dose: _____Method/Route: _____as prescribed by Physician

___Give Medication: _____ Dose: _____Method/Route: _____as prescribed by Physician

___ Call 911

Physician Signature Date

Parent/Guardian Signature Date

Emergency Contacts

1._____
Name Relationship Phone Number

2._____
Name Relationship Phone Number