Student Medical Action Plan

Students Name: _____Teacher: _____

Date of Birth: _____ Age: _____

Allergies: _____

Action plan for: _____

IF YOU SEE THIS	DO THIS

NOTE: By signing this document the parent/guardian and/or student authorizes sharing this information with school personnel who have a legitimate need for knowledge of this information.

Family Contact Information:

Mother: _____ Father: _____

Cell: _____ Cell: _____

Work: _____ Work: _____

Home: _____ Home: _____

Emergency Contact:

Name: _____ Phone: _____

Special Instructions: _____

_____

_____

_____ _____

School Nurse Signature/Date Parent/Guardian Signature/ Date