SCHOOL-BASED MEDICAL PLAN

Medical Care Plan Date:____________________________________Valid for the school year:_____-______

TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN:

Student Information:

Student Name:____Birth Date:__________Grade:_______

Parent Information:

Parent/Guardian #1:_________________________________Address:____________________________________

Telephone: (H)_________________________(C)_____________________________(W)______________________

Parent/Guardian #2:_________________________________Address:____________________________________

Telephone: (H)_________________________(C)_____________________________(W)______________________

Other Emergency Contact:__________________________________Relationship:___________________________

Telephone: (H)_________________________(C)_____________________________(W)______________________

Information to be shared with teachers/staff:

____

____

☐ Additional steps necessary (see below)

☐ No additional steps necessary

MEDICATION:_

☐ No medication necessary

☐ Non-Prescription Medical Form Attached ☐ Prescription Medical Form Attached

TO BE COMPLETED BY THE STUDENT'S DOCTOR:

Doctor's Name:____Phone:_____________________________

Diagnosis:____

Describe how this diagnosis affects the student's daily activities:

____

____

Call 911 if:____

TO BE COMPLETED BY THE SCHOOL (additional steps):

1. ____
2. ____
3. ____
4. **Inform parent if:**____

Parent Signature:____Date:_____________________