MEDICAL ACTION PLAN

Care Plan for: _______________________________  Date: ____________________

Please explain the condition
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Warning signs / early symptoms
Specifically detail what the teachers should be looking for and what they should do in response:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Advanced Symptoms
Specifically detail what the teachers should be looking for and what they should do in response, including any medication that should be given:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Emergency Symptoms
Specifically detail what the teachers should be looking for and what they should do in response, including any medication (including dosage) that should be given:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Special accommodations that you are requesting for your child (based on your doctor’s recommendation and subject to approval of the center director):

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Approval of Plan

This plan must be filled out by the parent or physician and approved by the parent, physician and center director.

 Doctor’s Name (please print) Date

Doctor’s Signature Phone Number

Doctor’s Address

 Parent’s Name (please print) Date

Parent’s Signature Phone Number

 Director’s Name (please print) Date

Director’s Signature Phone Number