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):

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Is this a temporary ____ or chronic ____ condition?

Please specify a date or other factors that indicate termination of this plan:

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

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