Student Health Action Plan

Date Received: _____	
Entered in Aeries: _____	
Copies to:	
Club M	CUME
P.E.	SpEd
Teacher	Yard Duty

Student Name: _____ **Class:** _____

Parent: _____ **Phone:** _____

Doctor: _____ **Phone:** _____

Medical Issue/Diagnosis: _____

Symptoms: _____

_____

_____

_____

_____

_____

Treatment/Care: _____

_____

_____

_____

*If treatment includes any medications to be administered at school please also provide a signed and completed 'Permission for the Administration of Medication' Form.

When to call parent: _____

_____

When to call doctor: _____

_____

Additional Information to help us support your family: _____

_____

_____

_____

This form was completed by: _____

Parent Signature: _____ **Date:** _____