General Medical Action Plan

Office Use Only
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- ☐ Notify RN, copy sent via pony

Initials/date____________________

Student Name ________________________________ DOB____/_____/______

Building______________________________________ Grade__________ School Year________/________

**This section below to be filled out by MEDICAL CARE PROVIDER

Symptoms/Concerns	**School Staff Actions**
General Symptoms: ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	School Staff Should: ______________________________ ______________________________ ______________________________ Can Student Remain in School? ❒ YES ❒ NO If No, When Can Student Return? ____________________ ______________________________

Student Should Be Sent Home if:	Student May Return Back to School When:
______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________

Emergency Services Should Be Contacted if:	Student May Return Back to School When:
______________________________ ______________________________	______________________________ ______________________________

Other symptoms and actions to be taken____
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Physician Signature____ Date_________________________

Physician Name____ Phone________________________

I have reviewed this plan with my child's physician. I give Carman-Ainsworth school staff permission to treat my child according to this plan. I understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety I will update the school with any changes to my child's plan. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding this plan.

Parent/Guardian Signature____________________________________ Date _________________________

Parent/Guardian Name_______________________________________ Phone________________________

For other chronic illness conditions, such as diabetes, asthma, seizures or allergies, please use specific care plan forms. This form is for other illnesses and conditions that do not fit into those categories.

**Must have Authorization to Administer Medication form for any medications.

Updated/Reviewed 11/21 KJ