Effective Date: _____

ROMEO COMMUNITY SCHOOLS

**Insert Student Picture**

# Student Medical Action Plan

| STUDENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| **Student Name:** | | **DOB:** | | **Grade:** | |
| **Parent Name:** | | **Phone:** | | | |
| **Parent Name:** | | **Phone:** | | | |

| EMERGENCY CONTACT | | | |
|---|---|---|---|
| **Contact Name:** | | **Contact Relationship:** | |
| **Phone 1:** | | **Phone 2:** | |

| MEDICAL CONDITION/DIAGNOSIS (CHECK ALL THAT APPLY) | | |
|---|---|---|
| ☐ | **Allergy** (list allergens) | |
| ☐ | **Asthma** | |
| ☐ | **Diabetes** | |
| ☐ | **Seizure Disorder** | |
| ☐ | **Other** (be specific) | |

## SYMPTOMS/SIGNS TO LOOK FOR TO ADMINISTER MEDICATION

**TO BE COMPLETED BY THE PHYSICAN:** *Tell us what specific symptoms/signs that staff should look for regarding the child's medical condition in order to know when to administer prescribed medication.*

## TREATMENT PLAN

**TO BE COMPLETED BY THE PHYSICAN:** *Describe the specific treatment plan that staff should follow when symptoms appear for the child.*

## MEDICATION AND DOSAGE

*List the specific medication and dosage for your child (include daily medications)*

| Emergency Med | Medication | Dosage | Special Instructions |
|---|---|---|---|
| ☐ | | | |
| ☐ | | | |
| ☐ | | | |
| ☐ | | | |
| ☐ | | | |
| ☐ | | | |

*Does this student need to self-carry medication?* ☐ Yes† ☐ No

*Does this student receive district transportation?* ☐ Yes* ☐ No

†If yes, the *Request for Self-Possession/Self-Administration of Medication* form is required to be completed.

*If yes, a copy of this plan must be included on all buses that the student rides.

## ADDITIONAL INFORMATION

**TO BE COMPLETED BY THE PHYSICAN OR AT THE SCHOOL ORGANIZATIONAL MEETING:** *This space is available for additional pertinent instructions, special considerations, or precautions from either the physician's office or the consultation meeting at school.*

## AGREEMENT AND SIGNATURE

*By submitting this medical plan, I affirm that the facts set forth in it are accurate and complete.*

**Parent/Guardian Name:** _____ **Signature:** _____

**Date:** _____

**Physician Name:** _____ **Signature:** _____

*You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this medical action plan.

**Date:** _____

**Practice Name, Phone, and Address:** _____