MORGAN COUNTY SCHOOL DISTRICT RE-3
Health Care Action Plan—Basic

Student Information

Name:_____ DOB: _____

ID#: _____Grade: _____ Parent/Guardian: _____

Address:_____ City/State/Zip: _____

Home phone: _____ Work phone: (mother) _____ (father) _____

Emergency contact:_____ Phone: _____

Primary Care Provider: _____ Phone: _____

Specialist: _____ Phone: _____

Medical Information

Description of illness or condition: _____

_____

_____

Medications

Medications/dose/time: _____

_____

Restrictions

Physical restrictions:

_____

_____

Concerns/Actions/Comments

Concerns/urgent action(s)/Comments: _____

_____

_____

Please return form to:

School Health Office:_____

Fax: _____

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

School Nurse_____ Date_____

Parent/Guardian _____ Date _____

Health Care Provider _____Date _____

By signing this Care Plan, and as the parent/guardian of the above named student, I give my permission for my student's healthcare provider to share information with the School Nurse about the administration of this medication