MATTOON COMMUNITY UNIT SCHOOL DISTRICT #2

MEDICAL ACTION PLAN

_____ Age/School_____ Grade_____
Student's Name

_____
Student's Teacher(s)

Emergency Contact Information:

_____
School Nurse Name Cell Phone #

_____	_____
#1 Parent/Guardian Name	#2 Parent/Guardian Name
_____	_____
Home Phone #	Home Phone #
_____	_____
Work Phone #	Work Phone #
_____	_____
Cell Phone #	Cell Phone #
_____	_____
#1 Alternate Emergency Contact Name	#2 Alternate Emergency Contact Name
_____	_____
Phone #	Phone #
_____	_____
Primary Care Physician Name	Primary Care Physician Phone #
_____	_____
Physician for this condition	Physician for this condition Phone #

Medical Condition: CAH

If these symptoms present themselves, (list your child's symptoms) _____

_____

_____

_____

This action is to be taken_____

_____

_____

PLEASE TURN FORM OVER AND COMPLETE BOTH SIDES

Daily Medication Plan (home and if needed, at school)

Name	Amount	When to Use
1.		
2.		
3.		
4.		

Please include any other information that you feel will be helpful to the school nurse and your child's teachers to be able to assist your child when having a headache.

To the best of my knowledge all the information provided here is true, correct and accurate.

Parent/Guardian Signature Date