

20___ Medical care plan for education

To be completed by the parent/guardian, for supervising staff and emergency medical personnel.

PLEASE PRINT CLEARLY

Child's name

Class

Condition (Title and description)

Photo of child

Symptoms

Action to be taken

Does this child usually tell an adult if s/he is experiencing symptoms?

Yes

No

Does this child need to take medication at school for this condition?

Yes

No

Does the condition impact on this child's learning at school?

Yes

No

If YES, please describe

Parent/Guardian

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Signature

Name

Date

Emergency Contact Information

Contact name

Phone

Mobile

Email
