2008/2009

St. Matthew School

Health Care Plan for:

____

Student's Name ___________________Grade/teacher ___________
Date of birth ______________________
Diagnosis/Student condition ________________________________

Action Plan

Actions to be taken:

____

Medication, Dosage and Frequency

____

Medication delivered to school ______________________________

Parent Contact

____

MD contact in emergencies _________________________________
MD signature: ____

School nurse will provide the following information to school staff

____

____

I give permission for my child to be given the above care
Parent signature____
Date____

School nurse signature ____________________
Date ___________________________________