

**St. Matthew School
Health Care Plan
Frequent Headaches**

Student's Name _____ Grade/teacher _____

Date of birth _____

Student Condition/Diagnosis _____

Action Plan

Actions to be taken:

Medication, Dosage and Frequency:

Medication delivered to school _____

Parent Contact _____

School nurse will provide the following information to school staff

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

MD signature _____

Parent signature _____

Date _____

School nurse signature _____

Date _____