Lake Orion Community Schools

Medical Action Plan (type/print legibly)

Student's Photo Here

Student's Contact Information

Student Name	
Student Date of Birth	
Street Address	
City ST ZIP Code	
Primary Phone	

Primary Person to Notify in Case of Emergency

Name	
Street Address	
City ST ZIP Code	
Primary Phone	
E-Mail Address	

Secondary Person to Notify in Case of Emergency

Name	
Phone number	

Medication Student Takes Regularly (list specific medications and dosages)

Medication Reaction History (please be specific)

Medical Condition

Symptoms/Signs to look for to monitor and/or administer medication:

Tell us what specific symptoms/signs that staff should look for regarding the child's medical condition in order to know when to administer prescribe medication.

Treatment Plan

List the specific treatment plan that staff should follow when the symptoms/signs appear for the child. Step by step instructions need to be listed.

Medication and Dosage

List the specific medication and dosage for the child.

Agreement and Signature

By submitting this medical plan, I affirm that the facts set forth in it are true and complete.

Parent/Guardian's Name (printed)		Physician's Name and address (printed/stamp)	
Parent/Guardian's Signature		Physician's Signature	
Date		Date	