MEDICAL ACTION PLAN

Date: ___________
Child Name: ____ Date of Birth: __________________
Parent(s) Name: ____
Center/Classroom Name: ________________________FSW: ______________________________

Medical Diagnosis: ____

Medication(s) to be administered at school:
____
____
____

Limitations/Restrictions (Doctor's note or signature required):
____
____
____

Plan of Action/Additional Instructions:
____
____
____
____
____
____

Medical Professional Signature: ______________________________Date: __________________
(If completed by a doctor)

This portion completed by EC Nurse/Health Services Director:

Training for staff: □ Yes □No Training date: ______________________________________
Type of Training Provided: ____
____
____

Medical Action Plan reviewed by (staff initials):
____

Parent Signature: ___________________________________Date: ________________________

Staff Signature: _____________________________________Date: ________________________

Early Childhood Nurse: _______________________________Date: ________________________

Health Services Director: _____________________________Date: ________________________

Revised 4/2018