Nelsonville – York City School District
Medical Action Plan

Student Name: _____ DOB: _____ Age: _____
Home Room Teacher: _____ Grade: _____
Parent/Guardian: _____ Phone (C): _____
Phone (H): _____ Phone (W): _____
Health Care Provider/Physician Treating Student for Condition: _____
Phone # _____
Other Health Care Provider: _____
Phone: _____

Medical Condition/Diagnosis: _____

_____

Description of Condition/Diagnosis: _____

_____

Medications for Condition/Diagnosis: _____

If medications are required at school a prescribed medication authorization form must be completed

Special Needs/Arrangements (including dietary needs): _____

_____

_____

Medical Emergencies with in the past two years involving Condition/Diagnosis: _____

_____

Contact parent/guardian if: _____

Contact health care provider if: _____

Contact Emergency services 911if: _____

_____

Plan of Action at school for Condition/Diagnosis: _____

_____

_____

_____

Other Considerations: _____

_____

_____

Physician Signature: _____ Date: _____

☑ I authorize the licensed healthcare professional to talk with the prescriber to clarify Medical Action Plan.

Parent/Guardian Signature: _____ Date: _____

Please attach an extra sheet of paper for additional charting space