Sand Springs Public Schools

Health Action Plan

TO BE FILLED OUT BY PARENT/GUARDIAN ***AND*** PHYSICIAN

General Information:

Name of Student _____ School _____

Emergency Contact _____ Phone _____

Treating Physician _____ Phone _____

It is important to have current health information and directions for care of student's health needs at school. Please check with your child's doctor for assistance in completing this form. Both parent/guardian and physician signatures are required. *Information received through this Health Action Plan is considered confidential, but will be provided to school district personnel to assist in the medical concerns and safety of your student. Please notify the school nurse and/or school of any changes in student's health condition or through a physician's order that would affect this Health Action Plan.*

TO BE COMPLETED BY PARENT/GUARDIAN

HEALTH CONCERN(S): _____

_____

How long has your child had this condition? _____

List any past operations, injuries, major illnesses, or hospitalizations and give dates: _____

_____

Is the child routinely seen by a doctor? ☐ Yes ☐ No

Does student need any special assistance needs? ☐ Yes ☐ No

If yes, please explain: _____

Does your student require medication that needs to be administered at school? ☐ Yes ☐ No

If yes, have physician complete and sign Medication Authorization Form.

TO BE COMPLETED BY PHYSICIAN *If yes to any item, please explain (attach addendum if needed)*

Is there any emergency treatment needed for this student's health condition? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does the student have special needs that need to be attended to? (i.e., tube feedings, breathing treatments, etc.) ☐ Yes ☐ No *If yes, fill out the next page*

Additional comments: _____

_____

Physician Signature (required) _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____