NAMPA CHRISTIAN SCHOOLS

Medical Condition Action Plan

Student: _____
Grade: _____
Parent/Guardian: _____

Medical condition:

Does the student take medication to manage his/her condition? Yes ☐ No ☐

Medication Name	Dose	Needed at school
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Please list any specific comments/concerns you wish us to be aware of regarding your student:

Has your student had any emergencies or severe symptoms related to this condition? Yes ☐ No ☐
If yes, please describe:

If this reaction occurs at school, I request the following steps be taken:

1. _____
2. _____
3. _____
4. _____

Parent/Guardian Signature:

_____

Date: _____