

SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

STUDENT MEDICAL ACTION PLAN

Student's Name: _____ Date of Birth: _____

Grade: _____ School: _____ Homeroom Teacher: _____

Physical Education Days and Times: _____

Emergency Information		
Parent's Name		
Mother's Home Phone Number	Cell Number	Work Number
Father's Home Phone Number	Cell Number	Work Number
Physician's Name	Physician's Phone Number	
In Case of Emergency Contact:		
1.		
2.		
3.		

Please give a brief description of your child's health condition and the steps you would like school personnel to take in case of an emergency with your child.

HEALTH CONDITION: _____

Physical restrictions: Yes/No - If yes, please indicate restrictions and for how long.

Academic restrictions: Yes/No - If yes, please indicate restrictions and for how long.

Action To Be Taken

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

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Note that if a medication is to be administered during the school day, the medication consent form must also be signed and accompany this form.

This information will be shared with the child's classroom teacher, building medication administrator, physical education teacher, and other staff on a need to know basis to ensure safe management of your child's health condition.

Parent Signature _____

Date _____

School Nurse Signature _____

Date _____

Physician Signature _____

Date _____

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Jenny Penn MSN, RN at jpenn@newlondon.k12.wi.us. If medication is needed for this concern, you must also fill out a medication consent form. Thank you.

Any questions or changes in this plan please inform the School Nurse as soon as possible. Thank you.

Jenny Penn, MSN, RN - School District Nurse

Middle School
Lincoln
Sugar Bush

982-8532
982-8540
715-752-4135

High School
Parkview
Readfield

982-8420
982-8538
667-4265