School District of New London
School Health Services

STUDENT MEDICAL ACTION CARE 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: _____

_____

_____

_____

Action To Be Taken

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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 _____ Dated _____

Physician Signature _____ Dated _____

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

Susan Resch, RN, BSN

Middle School	982-8602	High School	982-8433
Lincoln	982-8540	Parkview	982-8538
Sugar Bush	715-752-4135	Readfield	667-4265