Ira Independent School District

Medical Action Plan

Student Name: _____ DOB: ___/___/___

Parents/Guardians caring for child: _____

Home phone: _____

PRIMARY CONDITION

Diagnosis:	Date of diagnosis:
Symptoms/basis of diagnosis:	
Special instructions/considerations for school:	
Does student take medication at home?	
Will student need medication while at school?	

MEDICATION

Medication at home:

Name of medication	Dose	Frequency	Time of day	Special instructions

Medication at school:

Name of medication	Dose	Frequency	Time of day	Special instructions

COMORMID/OTHER CONDITIONS

Diagnosis:	Date of diagnosis:

_____ _____

Physician signature Date