Garretson School District 49-4
505 2nd St. PO Box C
Garretson, SD 57030
Phone (605) 594-3451
Fax (605) 594-3443

Year 20___/___

Medical Condition Action Plan

Students Name_____ Date of Birth____/____/_____
Bus: ☐ Yes ☐ No Teacher_____Grade_____
Parent/Guardian_____ Phone_____
_____ Phone_____
Emergency Contact 1)_____ Phone_____
2)_____ Phone_____
Physician:_____ Phone_____
Hospital Preference:_____ Phone_____

My child's Medical Condition/Concern:

_____

_____

_____

Year Diagnosed: _____

Does the medical condition/concern require school restrictions, modification and/or intervention?

If Yes, please explain_____

Does the student require any special procedures and/or treatments for their health condition/conern?

If Yes, please explain_____

Has the student been hospitalized for the medical condition/concern?

If Yes, please explan_____

Are medications required to control the medical condition/concern? ☐ Yes ☐ No

(*additional paperwork may need to be completed)*

Please list prescription and over the counter medication your child will need during the school day:

Medication	Time(s)	Reason

***Children K-5** are not allowed to carry and self-administer any medications, including cough drops. Exceptions are made for Asthma and Anaphylactic medications. Medications may be administered from the health office with proper Medication Administration Forms. Forms must be completed by parent/guardian and all medications delivered to the health office by parents in original properly labeled container.

***A Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New health care plans must be completed yearly. Any updates throughout the school year should be submitted to the Nurse.

***In Garretson,** in the event of an emergency, EMS will be activated by a call to 911 at which time we will state the need to transport to hospital by ambulance. Trained school staff respond first, followed by Garretson volunteer ambulance and fire departments.

**This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may result from these omissions.*

By signing below, I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentially. I also give my permission for the school nurse/aide to contact the Primary Care Physician if further information or clarification is needed.

Parent/Guardian Signature _____ Date_____

School Nurse Signature _____ Date_____