# ACTION CARE PLAN: COMPLEX MEDICAL

Student's Name: ______________________________________________Age: _________ DOB: ___/___/______

**EMERGENCY INFORMATION:**

Parent/Guardian Name: ___________________________________________________________________________

Mother: Cell: ________________________ Work: ________________________ Home: ________________________

Father: Cell: _________________________ Work: ________________________ Home: ________________________

Emergency Contact (different from above) Name & Phone: ________________________________________________

Physician Name: ________________________________________________ Phone: ___________________________

Physician Address: _______________________________________________________________________________

**MEDICAL CONDITION or DIAGNOSIS:** _________________________________________________________________

**Description of Condition or Diagnosis:**

______________________________________________________________________________________________

**Signs & Symptoms:**

______________________________________________________________________________________________

| *If these symptoms occur:* → | *Perform these actions:* |
|---|---|
| | |

**Name of ALL Current Medication(s): Including: Dosage/Time/Frequency:**
**(Please complete our MANDATORY *Medication Dispensing Form* if medication is to be given during camp):**

| Medications | Medication Dosage, Frequency/Times(s) | Side Effects |
|---|---|---|
| | | |

**Any additional information:**

______________________________________________________________________________________________

Signature of Parent/Guardian: ______________________________________________Date: ________________