Autism Academy for Education & Development
Student Medical Action Plan

Student Name: _____ Goes by (*if different):* _____

DOB: _____ Current Grade: _____ Current Campus: _____

Parent/Guardian: _____ Preferred Hospital: _____

Physician: _____ Physician Telephone #: _____

Student Health Condition(s): _____

IF YOU SEE THIS	DO THIS

Please be sure to update your student's information in the campus office if any medication or medical changes occur.

Parent/Guardian Signature: _____ Date: _____