Health Care Plan

Name of Student: ______________________________

Date of birth: ___ /___ /______

Contact Parents/Legal Guardian: ____

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Diagnosis/Health Issue: ____

Possible symptoms: ____

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Medication provided to the Franconian International School e.V.:

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Action plan in case of symptoms:

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Declaration:

I herewith declare that the above stated action plan can be carried out by staff of the Franconian International School e.V.
I will notify the Franconian International School e.V. as soon as there are any changes in condition or action plan

_______________ ______________________________

Date Signature Parent/Legal Guardian